MEANINGS AND INTERPRETATIONS ATTRIBUTED TO ALCOHOL ABUSE AND ALCOHOL DEPENDENCE BY MEDICAL AND SURGICAL NURSES: An Interpretive Descriptive Study

by

HEATHER ANN PERRY

B.Sc.N., University of Victoria, 1999

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

(The School of Nursing)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

October 2004

© Heather Ann Perry, 2004
Library Authorization

In presenting this thesis in partial fulfillment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Heather Ann Perry
Name of Author (please print)

06/10/2004
Date (dd/mm/yyyy)

Title of Thesis:
Meanings and Interpretations Attributed to Alcohol Abuse and Alcohol Dependence by Medical and Surgical Nurses

Degree: M.S.N. Year: 2004

Department of
School of Nursing
The University of British Columbia
Vancouver, BC Canada
ABSTRACT

The purpose of this study was to explore the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses practicing in an acute care facility. The study was undertaken to understand more about alcohol abuse and alcohol dependence, as these often remain unrecognized, undiagnosed, and untreated by health care professionals. Nine nurses were interviewed to gain an understanding of their perspectives and to develop insight into their experiences nursing patients using alcohol at risk levels.

An interpretive descriptive qualitative approach was used for data analysis, and five major themes and twelve sub-themes emerged from the findings of the study. The themes and sub-themes were representative of the nurses' experiences of screening and assessing patients for at-risk alcohol use, and of the nurses' experiences of caring for patients who were alcohol-dependent.

As part of the discussion of the study findings, a 'story' was created to represent a nurse-patient relationship such as typically occurs during a hospitalization experience. The major themes and sub-themes were discussed in the context of the various sections or stages in this 'story'; they were considered in relation to: the necessity and importance of establishing a nurse-patient relationship; the lack of consensus regarding theoretical perspectives of alcohol dependence; the occurrence of unanticipated alcohol withdrawal and subsequent safety issues for the patient and nurse; and patient teaching initiatives regarding at-risk alcohol use.

The study findings offer insight into the practice setting and the challenges that nurses may experience when nursing patients using alcohol at risk levels. These findings have implications for nursing practice, administration, nursing education, and research, to support medical and surgical nurses in meeting the complex health care needs of patients using alcohol at risk levels.
# TABLE OF CONTENTS

Abstract .................................................................................................................. ii  
Table of Contents .................................................................................................... iii  
Acknowledgements ................................................................................................... vi  
Chapter 1: Introduction .......................................................................................... 1  
  Background to the Problem ..................................................................................... 1  
    The Effects of Alcohol Use on the Health of Canadians ..................................... 3  
    The Effects of Alcohol Use on the Canadian Economy ..................................... 4  
  Obstacles and Barriers in Seeking and Accessing Treatment Services ............... 5  
    The Stigma of Alcohol Abuse ............................................................................ 5  
    Dual-Diagnosis Health Care Access .................................................................. 6  
    Delays in Identifying Alcohol-Related Problems – Health Consequences ........ 7  
  Screening and Assessing for At-Risk Alcohol Use ............................................. 7  
    The Role of Nurses in Screening and Assessment ........................................... 8  
    A Preventative Approach .................................................................................. 9  
  Summary of the Problem .................................................................................... 10  
  Purpose of the Study .......................................................................................... 11  
  Research Question ............................................................................................. 11  
  Significance of the Study ................................................................................... 11  
  Summary ............................................................................................................ 12  
Chapter 2: Review of the Literature ................................................................. 13  
  An Historical Account of Alcohol Use – Influencing the Present Day ............... 13  
    Alcohol Use in Antiquity .................................................................................. 13  
    Alcohol Use in Medieval and Renaissance Europe ......................................... 14  
    Perceptions of Alcohol Use in the Modern Era .............................................. 15  
  Explanatory Theoretical Perspectives of Alcohol Dependence ......................... 17  
    Alcohol Dependence Perceived as a Moral Failing ....................................... 18  
    The Disease Perspective .................................................................................. 19  
    The Psychological Perspective ....................................................................... 21  
    The Sociocultural Perspective ....................................................................... 21  
    The Biopsychosocial Perspective .................................................................... 22  
    A Holistic Model ............................................................................................. 23  
  Substance Abuse, Alcohol Abuse and Alcohol Dependence: Nurses’ Attitudes .... 24  
    Nurses’ Perceptions of Alcohol Dependence as Affected by Myths, Beliefs, and Biases .............................................................................................................. 24  
    Nurses’ Attitudes Towards Substance Abuse ................................................. 25  
    Nurses’ Attitudes Towards Alcohol Abuse and Alcohol Dependence ............ 26  
  Discussion ........................................................................................................... 34  
  Summary ............................................................................................................ 35  
Chapter 3: Methodology ...................................................................................... 37
Chapter Four: Findings

Establishing the Nurse-Patient Relationship

What to Name It?

The Disease Perspective .......................... 51
The Psychological Perspective ..................... 52
The Moralistic Perspective ........................ 53
Participants' Underlying Attitudes Towards Alcohol Use ................................. 54

Slipping Through: When Screening and Assessment is Compromised ............................. 55

Communications with Medical Staff ..................................................... 56
Communications with Nursing Colleagues ............................................. 58
Communications with Patients ............................................................. 59
Working with the CAGE Questionnaire ................................................. 61
Attempting to Elicit Information ........................................................... 63

Getting the Brunt of It: The Consequences of Undetected Alcohol Withdrawal ...................... 65

Concerns for Patient Safety ................................................................. 66
Concerns for Nurse and Staff Safety ....................................................... 67

Opening the Door to Patient Teaching .................................................... 69

Nurse-Initiated Patient Teaching: Opportunities and Barriers ..................................... 70
Nurses' Perceptions of Patient Reluctance to Patient Teaching .................................. 72
Locking Out the Elderly ........................................................................... 73

Summary ................................................................................................. 75

Chapter Five: Discussion of the Findings ............................................................................. 76

The Structure of the Discussion: Thematic Sections in the Nurse-Patient “Story” .................. 76

Section One: Beginning the Nurse-Patient Relationship ...................................................... 79

The Therapeutic Relationship ............................................................................. 80
The Unilateral Relationship ................................................................................. 81
The Problem of Therapeutic Relationships with Alcohol-dependent Patients ...................... 83
| Section Two: Screening and Assessment for At-Risk Alcohol Use | 83 |
| Working with the CAGE Questionnaire | 84 |
| “Slipping Through” | 86 |
| Incentives to Disclose during Assessment | 89 |
| Nursing Education for Screening | 89 |
| Section Three: Negotiating the Nurse-Patient Relationship | 91 |
| Participants’ Perceptions of Patients’ Reluctance | 92 |
| Interpersonal Factors | 95 |
| Environmental Factors Influencing Nursing Practice | 96 |
| Undetected Alcohol Withdrawal | 99 |
| Section Four: Patient Teaching for At-Risk Alcohol Use | 100 |
| Nurses’ Identified Patient Teaching Practices for At-Risk Alcohol Use | 101 |
| Patient Teaching with Older Alcohol-Dependent Patients – A Special Case? | 102 |
| Limiting Patient Teaching Initiatives Regarding At-Risk Alcohol Use – What’s Missing... | 103 |
| Summary | 104 |
| Chapter Six: Summary and Conclusions | 106 |
| A Summary of the Study | 106 |
| Study Implications | 108 |
| Implications for Nursing Practice | 108 |
| Implications for Nursing Administration | 110 |
| Implications for Nursing Education | 112 |
| Implications for Future Research | 113 |
| Conclusion | 114 |
| References | 115 |
| Appendix A | 131 |
| Appendix B | 136 |
| Appendix C | 137 |
| Appendix D | 138 |
| Appendix E | 140 |
| Appendix F | 141 |
| Appendix G | 142 |
| Appendix H | 145 |
ACKNOWLEDGEMENTS

First and foremost, I wish to acknowledge the nine medical and surgical nurses who so generously shared their experiences through the telling of their stories. It was an honor to have had the opportunity to interview you during this project and I hope I have represented your experiences well. Your contributions made this research possible. Thank-you.

I would like to acknowledge the members of my thesis committee, Dr. Carol Jillings, Dr. Margaret Osborne, Ms. Marelyn Rugg, and Dr. Sally Thorne. I thank each of you for sharing your expertise, as well as for your support and encouragement during the project. Marg, I want to express my special gratitude for your continued faith, support, and belief in the importance of this study.

I would like to acknowledge the support and understanding of my family and friends for the many times that I was not able to participate in “life”. I would also like to extend a special thank-you to my dear friend Janet Ray, who was ever-present and available for consultation regarding “Ethyl”, sometimes into the “wee” hours of the morning.

I would like to thank the Alumnae Association of the Royal Jubilee Hospital School of Nursing for their generous financial contribution to this project; I appreciate in particular the warm and caring correspondence from Laura Davison.

Finally, I would like to acknowledge the love and support of my mother, Edna A. Jackson. Mom is the original nurse in my family and received her R.N. at Moose Jaw Union Hospital in 1938. She continued her studies at Royal Victoria School of Nursing in Montreal, where she obtained her Post Graduate Diploma in maternity nursing in 1939. Her strength of spirit and quiet determination continues to inspire me. I would also like to acknowledge my father, the late W. Stanley Jackson, for his unfailing belief in the importance of education and for his support, from the earliest days of my scholastic endeavors. I regret that he is only able to be present in spirit to share this accomplishment.
CHAPTER 1: INTRODUCTION

This study explores the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses, with a view to gaining insight into the screening and assessment of clients who may be using alcohol at risk levels. When such clients present at hospital with medical or surgical issues, their alcohol use may remain unrecognized, undiagnosed, and untreated by health care professionals. Without effective treatment interventions for the at-risk user of alcohol, there are substantial costs – both financial and social – for the individual, the family, the health care system, and society at large. The aim of this research is to generate nursing knowledge that can point to ways to improve nursing education and practice so that nurses are equipped to intervene effectively, thus ensuring that patients can have the opportunity to gain access to appropriate and timely health services. This study examines this issue using an interpretive descriptive inductive analytic approach to further understanding of the phenomenon, and add to the nursing knowledge base.

Background to the Problem

Alcohol is the oldest and most widely used psychoactive substance (Manwell, 1997) and the most commonly abused (Lieber, 1995). Not surprisingly, alcohol abuse and dependence (see Appendix A: Terminology) create significant threats to health, worldwide. The World Health Organization (WHO) estimates that there are about 2 billion people worldwide who consume alcoholic beverages and 76.3 million with diagnosed alcohol-use disorders (World Health Organization, 2004). A report commissioned by the WHO and the World Bank, The Global Burden of Disease, ranks alcohol dependence as the fourth leading cause of disability.

---

1 The 'burden of disease' takes into account the impact of disability as well as the traditional impact of years of life lost due to mortality and morbidity when measuring the impacts of disease and risk factors on the health of a population.
and healthcare burden (WHO, 2002). Overall, there are causal relationships between alcohol consumption and more than 60 types of disease and injury (WHO, 2004). In the United States an estimated 14 million adults abuse or are dependent on alcohol (Grant, 2000). In Europe alone, alcohol consumption was responsible for over 55,000 deaths among young people aged 15 to 29 years in 1999 (Rehm & Gmel, 2002). In Canada, based on the 1996-97 National Population Heath Survey (NPHS) 17.8% of Canadians and 23.4% of the past-year drinkers surveyed reported consuming alcohol beyond the low-risk drinking guidelines (Statistics Canada, 1998b).

Historically, the use of alcohol has been intricately interwoven into the social and cultural fabric of most European and North American nations (Winnington & Rassool, 1998). How society considers alcohol use is a complex issue, particularly since most people generally do not consider alcohol to be a drug with psychoactive and addictive properties (Winnington & Rassool). Alcohol use has a long history, and continues to be used for a wide variety of reasons, both medicinally and non-medicinally. Medicinally, it is used for its stimulant, sedative, and anesthetic qualities. When alcohol use – whether medicinal or non-medicinal – impinges on the user’s health or ability to function, or both, it may be considered as at-risk alcohol use or alcohol abuse (Appendix A: Terminology). Non-medicinal uses of alcohol may be related to celebrations, social activities, and religious ceremonies; it is used as a food additive (both for its flavouring and preservative properties); and even as a fuel (Health Education Authority, 1994).

The prevailing views of a given society on alcohol are often mirrored in its legal and moral dictates, with alcohol abuse often being viewed as related to criminal activity, and with moral weakness or failure. Certainly, alcohol abuse has long been known to be associated with mortality and morbidity; it affects individuals in a wide variety of ways and creates serious physical, social, and psychological health problems. In Canada, the most common of these
problems are those affecting physical health (5.1% of Canadians) and financial position (4.7% of Canadians) (Statistics Canada, 1994).

The Effects of Alcohol Use on the Health of Canadians

Nearly one in ten Canadians (9.2%) reports having a problem with drinking (Single, Brewster, MacNeil, Hatcher, & Trainor, 1995). The Canadian Centre for Substance Abuse (CCSA) and the Centre for Addiction and Mental Health (CAMH) (1999) reports that 6,701 Canadian deaths were attributed to alcohol abuse in 1992, and that, typically, these deaths were due to motor vehicle accidents, complications of liver disease, or suicide. Nearly half of the Canadians who died in motor vehicle accidents in 1993 had alcohol in their blood (Canadian Centre for Substance Abuse (CCSA) and Centre for Addiction and Mental Health (CMAH), 1999). In 1999, 1,832 British Columbian deaths were alcohol-related (Ministry of Health Planning, 1999). According to a recent Canadian epidemiological survey, approximately 120,000 British Columbians have a high probability of alcohol dependence and another 224,000 have some indications of dependence (Statistics Canada, 2004). In Vancouver alone, between 1991 and 1998, an average of 297 deaths were related to alcohol as compared to 147 related to drug use (McLean, 2000). In Vancouver, alcohol abuse is associated with more deaths and greater health impacts than is illicit drug use (McLean).

A recent report by the B.C. Provincial Health Officer states that although there are no B.C. data on the frequency of Fetal Alcohol Syndrome (FAS), “Estimates are that for every thousand babies born, up to three have the full features of FAS, while an additional four or five will have significant long-term disabilities related to partial FAS” (Kendall, 2002, p.11). The report also notes that children with the full features of FAS may have neurological damage, restricted growth, and physical and mental handicaps; children with partial FAS often exhibit behavioural problems and learning disabilities (Kendall). Thus, Fetal Alcohol Spectrum
Disorder (FASD) – which includes both full and partial FAS – is associated with substantial social costs in addition to its economic burden on the health care system.

In British Columbia, the hospitalization rate for alcohol dependence syndrome has been stable for the last several years and is listed at 0.3 per 100,000 persons (Dandurand & Chinn, 2001). However, British Columbians spend more days in hospital per capita for alcohol-related problems than other Canadians (Single, Robson, Xie, & Rehm, 1996). In the year 2000, one tertiary care facility in Greater Vancouver listed 321 substance-related hospital admissions (Black, 2001).

The Effects of Alcohol Use on the Canadian Economy

The impacts of alcohol abuse take a significant toll on the Canadian economy. In 1993, Canadians spent a total of $7.5 billion dollars for alcohol abuse-related issues. This sum equates to $4.14 billion in lost productivity; $1.36 billion in law enforcement costs; and $1.30 billion in direct health care costs (Single, Robson, Xie, & Rehm, 1996). In British Columbia, the government directs almost ten per cent of its budget to problem substance use (Kaiser Youth Foundation, 2001).

Costs to the healthcare system originating from alcohol use are typically the result of hospitalizations due to accidental falls, alcohol dependence syndrome, and motor vehicle accidents. Tobacco, alcohol, and illicit drug use account for almost twenty-five per cent of British Columbia’s burden of disease (Strategic Policy and Research Branch, 2001). A 1999 comparative study of the Canadian provinces noted that British Columbia has the highest alcohol use of all the provinces, and that the numbers of residents engaging in at-risk alcohol consumption were on the increase (CCSA, 1999).
Obstacles and Barriers in Seeking and Accessing Treatment Services

When health care providers perceive addiction and alcohol dependence as a moral weakness or a psychological problem, this can hamper access to appropriate health services. For example, while the American Society of Addictions Medicine (ASAM) and the National Council on Alcoholism and Drug Dependence (NCADD) describes alcohol dependence from a disease perspective, there is also research that indicates that some health care providers’ understanding of alcohol dependence is rooted in a moralistic and culturally constructed rationale that assumes psychological and social factors, rather than addictive disease, have led to the client’s difficulties with alcohol (Goldbloom, 2002). Moreover, Goldbloom contends that despite the fact that recent literature provides overwhelming evidence of the significance of alcohol abuse, health care professionals continue to pay little attention to health problems related to substance use.

The Stigma of Alcohol Abuse

Significantly, recent scientific advances in the area of addictionology have not been adopted into clinical practice (Jack, Dulaney, Frese, & Krupnick, 2000). Harlow and Goby (1980) note ambivalent views among health professionals regarding whether or not to consider alcohol dependence as a disease; those who reject the disease hypothesis may consider alcohol dependence as a moral failing, as an evil, or as a sin, and may be unlikely to provide appropriately supportive care. Unfortunately, those who view the subject from a moralistic perspective may not acknowledge the alcohol-dependent client as being ill and in need of health services, making it more likely that the client’s disease condition could progress to a later more advanced stage of development (Bengers, Garretson, & van Oeers, 1996).

The persistent stigma often associated with alcohol abuse and alcohol dependence also poses a significant obstacle for the individual seeking alcohol-related health services. Lowe
(2000) notes that health care professionals often subject clients with alcohol abuse to attitudes that are judgmental and uncaring. This contributes to feelings of shame, blame, and secrecy that affect clients and their families, and often prevent those in need of help from seeking it (Lowe).

Nursing research has only recently begun to pay sufficient attention to this subject area; it was not until 1996 that a nursing journal instituted a regular feature on caring for the addicted patient (McCaffery, 1996). In a letter to the editor, McCaffery suggests that the content focus upon establishing that addiction means “a bad disease, not a bad person” (p.16). According to Faugier and Sargeant (1997) the stigma attached to substance abuse is an “active and dynamic process” (p.221). An early study by Wallston, Wallston and DeVellis (1976) found that when patients were labeled as “alcoholic”, nurses’ views of them were significantly more negative than patients not so labeled.

Such negative perceptions and treatment pessimism on the part of a nurse can have significant impacts on patient care. Link, Struening, Rahav and Phelan (1997) found that for the client experiencing mental health conditions and substance misuse, stigma was associated with beliefs of rejection, poor job prospects, and relationship difficulties.

**Dual-Diagnosis Health Care Access**

For the individual with alcohol (or substance) dependence and mental health disorders (the “dual diagnosis” client), knowing the appropriate health care entry point and successfully navigating the complexities of the system may be difficult. Current research identifies an increasing number of such individuals with mental health disorders and substance use problems or concurrent disorders (Gafoor & Rassool, 1998) and a recent Health Canada Report (2002) describes a long-standing problem of service delivery occurring as a result of the traditional separation of mental health services and substance abuse services. This dichotomy
has resulted in divisions of funding, administration, and policy organization. A Health Canada report described mental health clients as being relegated to psychiatric institutions and clients dependant on alcohol as not even being identified until the late stages of the addictive disease process (Health Canada, 2002). Moreover, if the health care needs of the alcohol-dependent client were addressed, it occurred in highly specialized treatment facilities.

Delays in Identifying Alcohol-Related Problems – Health Consequences

The earlier an alcohol-related health problem is identified, the easier it is to attain a positive outcome, as both biomedical and psychosocial effects are likely to be less entrenched in the cognitive processes. As a result, the patient is more receptive to counseling and treatment (Minicucci, 1994). However, various treatment barriers permit only a small number of clients with alcohol-related problems to be referred for further treatment options (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993). Thus, there would appear to be convincing evidence that meanings and interpretations of alcohol abuse and dependence attributed by health care providers may jeopardize patients’ access to appropriate health care services. These factors that could potentially affect patient access to treatment include the reluctance of many health care providers to accept the disease perspective, the persistence of stigma towards alcohol dependence and mental health conditions, and client confusion over access points for treatment initiatives.

Screening and Assessing for At-Risk Alcohol Use

Nurses working in the medical and surgical areas of the acute care setting are in an excellent position to screen and assess patients using alcohol at risk levels (Williams, Vince, & Salter, 1995; Burns & Adams, 1997). Studies indicate that a large proportion of patients using alcohol at risk levels seek access to acute care services for conditions that may appear
unrelated to alcohol use (Fry, 1980; Saunders & Lee, 1999). In the United Kingdom (UK), the
frequency with which individuals using general hospital services are at risk for alcohol
dependence has varied significantly between 22 per cent and 53.8 per cent (Chick, Lloyd, &
Crombie, 1985). Anderson’s study (1985) found that excessive drinkers present to UK health
services twice as often as other patients. In the United States, an estimated 20% to 50% of all
hospitalized admissions are related to the effects of alcohol abuse (West & Kinney, 1996;
Mayo-Smith, 1997; Ryan & Ottlinger, 1999). Hall and Zador (1997) found 8% of medical
patients were at risk for developing delirium tremens (DTs). Once a patient exhibits acute DTs,
a severe complication of alcohol withdrawal (Appendix A: Terminology), the mortality rate is
5% to 25% (Trevisan, Boutros, Petrakis, & Krystal, 1998). According to Ockene, Adams,
Hurley, Wheeler, and Herbert (1999), between 20% and 25% of adult patients seeking medical
treatment from primary care providers admit to drinking alcohol at high-risk (Appendix A:
Terminology) levels when appropriately screened. Yet, Moore et al (1989) found that fewer than
half of patients with alcohol-related problems were so identified by their physicians.

The Role of Nurses in Screening and Assessment

Although nurses are well positioned to screen and assess clients using alcohol at risk
levels (Williams, Vince, & Salter, 1995; Burns & Adams, 1997). Rowland and Maynard (1989)
found that nurses do not routinely screen patients for alcohol-related problems. In the
community setting, nurses screen for hypertension, diabetes, and high cholesterol levels but
screening and assessment activities for persons using alcohol at risk levels are not well
established (Stockwell, Sitharthan, McGrath, & Lang, 1994). Slack (1982) found that nurses
often miss the opportunity to provide clients with information and advice regarding alcohol use
because they fail to identify clients who use alcohol at risk levels. Rassool (1993) states that
even when nurses identify alcohol dependency, they “are reluctant to respond appropriately”
(p.1402). This reluctance suggests that some nurses may not be proactive in screening and assessing for at-risk alcohol use and intervening early in the addictive disease process, and as a result of this omission are practicing a style of health care delivery that is now considered outdated, that is, waiting until an illness has progressed to a symptomatic state. A preventative approach, in contrast, means addressing the problem before health symptoms arise.

A Preventative Approach

A preventative approach to substance abuse involves, among other strategies, a screening system and application of brief intervention (Sieck, Heirich, & Major, 2004). The goal of screening is to assess individuals for undetected substance abuse, or to identify those whose risk for substance abuse is high and determine whether there is a history of substance abuse problems. Screening allows for early intervention either before major problems develop or early in their development of at risk alcohol use (Sullivan, 1995). To be successful, screening instruments must quickly determine potential substance abuse and problems that require further investigation (Sullivan). When screening produces a positive result, additional assessment is necessary to better define the problem and determine if an intervention or referral is necessary (Sullivan). Many researchers consider the CAGE Questionnaire (Ewing, 1984) (see Appendix B), with its established reliability and validity, to be an effective screening tool for the acute care setting (Mayfield, McLeod, & Hall, 1974; Buchsbaum, Buchanan, Centor, Schnoll, & Lawton, 1991; NIAAA, 1987). Graham, Schultz, Mayo-Smith, Ries, and Wilford (2003) consider it to be the best screening tool currently available. Among the advantages of the CAGE is that it is easy to remember because the name of the tool is an acronym derived from the first letters of each of the questions. Research studies find that the CAGE Questionnaire correctly identified 75% of alcoholics and accurately eliminated 96% of non-alcoholics (Inciardi, 1994). Its advantages are that it takes less than two minutes to
complete, is easy to recall, and can be included within the general health assessment of a client (Allen, 1996). Following administration of the CAGE Questionnaire, the assessment process continues with the interviewer asking the patient about quantity and frequency of alcohol use. In the presence of a positive screen and assessment, the application of a brief intervention is an appropriate treatment strategy for patients with mild to moderate alcohol use (Heather, 1996; Finfgeld, 1999). A brief intervention may involve a short assessment, concise feedback regarding assessment findings, and succinct counseling that focuses on helping individuals change at-risk drinking habits (Finfgeld). With early intervention for the individual who uses alcohol at risk levels, it is possible to interrupt the progression of the addictive disease process. In the acute care setting, timely screening and assessment and the use of withdrawal management protocols, ensures that complications resulting in increased hospital stays and costly drains on health care resources - such as alcohol withdrawal syndrome - can be avoided.

In view of a preventative approach, it is essential that all health care providers possess the skills necessary to identify patients who are using alcohol at risk levels (Ryder & Edwards, 2000). A significant number of negative health conditions resulting from at-risk alcohol use may eventually require medical and surgical services. Nurses practicing within the medical and surgical areas cognizant of the negative health impacts of at-risk alcohol use can make a significant contribution to the well-being of these patients and their families. Timely screening and assessment to identify at-risk alcohol use can provide opportunities for early interventions and subsequent interruption of the harmful, addictive disease process.

Summary of the Problem

Alcohol abuse and alcohol dependence are significant problems for many Canadians, and many health and social problems that result from at-risk alcohol use might be avoided with early identification and the application of appropriate health interventions. However, in the
context of the health care setting, the patient using alcohol at risk levels often remains unrecognized, undiagnosed, and untreated by health care professionals. As a result, opportunities to intervene in a timely manner are missed and the addictive disease process continues unabated. Without effective treatment interventions, immeasurable costs continue for the individual, family, the health care system, and society at large.

Purpose of the Study

The purpose of this study was to explore and describe the meanings and interpretations attributed to alcohol abuse and alcohol dependence by medical and surgical nurses.

Research Question

The research question was: What are the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses?

Significance of the Study

This qualitative study offers an opportunity to advance nursing knowledge regarding the meanings and interpretations attributed to alcohol abuse and alcohol dependence from the perspective of medical and surgical nurses, and to gain insight into ways in which these interpretations might have an impact on the work of nurses. Additional information and knowledge in these matters can facilitate nursing educators’ presentation of information in ways that facilitate nursing practice. Furthermore, given that strategies for early detection and intervention of at risk alcohol use can help interrupt the addictive disease process, more insight into nurses’ understanding of these processes may help to improve the ability of nurses to implement them. We know that screening for at-risk alcohol use can help nurses to anticipate
complications such as acute alcohol withdrawal syndrome. This means that the nurse can be better prepared – that is, armed with accurate information to ensure optimal delivery of nursing services. Thus, early detection and intervention can avoid many of the complications that compromise patient outcomes, increase hospital stays, and incur greater health care costs. The role of the nurse is pivotal in facilitating the patient in accessing appropriate and timely health services; as we improve our knowledge of this role, we will be better prepared to deploy the appropriate interventions to interrupt the addictive disease process.

Summary

Alcohol abuse and alcohol dependence are important health care issues, as they contribute significantly to the global burden of disease; in Canada, there are substantial social and economic costs due to alcohol-related mortality and morbidity outcomes. A preventative approach to substance abuse entails effective screening, assessment, and intervention, and the importance of the nurses’ role in addressing these initiatives is paramount. However, when alcohol abuse and alcohol dependence remains undetected, the addictive disease process continues unabated, and the health consequences are substantial. There is evidence that the way health care providers, including nurses, understand addiction and alcohol dependence can affect the way they deliver health services, and thus can be a factor that hampers patients’ access to appropriate health care services. Because nurses are strategically positioned to screen and assess patients for at-risk alcohol use, and to offer interventions, we need to research the meanings and interpretations nurses attribute to alcohol abuse and dependence, to gain insight into the way these interpretations affect the practice of nurses who care for patients who use alcohol at risk levels.
CHAPTER 2: REVIEW OF THE LITERATURE

This review of the literature addresses perspectives pertinent to alcohol abuse and alcohol dependence and is representative of research in nursing, medicine, social work, and psychology. The literature review specifically addresses: (a) an historical account of alcohol use; (b) explanatory theoretical perspectives representative of alcohol dependence; and (c) nurses' attitudes toward substance abuse in general and alcohol abuse and alcohol dependence in particular, along with some common societal myths, beliefs, and biases pertaining to alcohol abuse and alcohol dependence. I identified research studies through computerized databases that included: (a) Cumulated Index to Nursing and Allied Health Literature (1982 to present), (b) Academic Search Premier (1984-present), (c) PsychINFO (1887-present) and, (d) Medline (1966-present). The descriptors I used were: ‘theoretical perspectives’, ‘addiction’, ‘myths and beliefs’, ‘societal impact’ ‘nurse attitudes’, ‘alcoholism’, and ‘substance abuse’. During the research process, I examined the names of authors that recurred in the literature for further information, and reviewed current texts and studies for relevant citations.

An Historical Account of Alcohol Use – Influencing the Present Day

Historically, viewpoints and strictures regarding alcohol use, alcohol abuse and alcohol dependence have included a range of moralistic, legal, psychosocial, and medical perspectives. These diverse perspectives, or variations of them, date from antiquity and have persisted into the modern era.

Alcohol Use in Antiquity

The first known attempts in law to regulate alcohol consumption are in the Law Code of Hammurabi, written in about 1700 B.C., which contains laws governing the operation of
drinking houses (Sournia, 1990). In the fifth century B.C., Plato wrote guidelines for appropriate use of alcohol - forbidding wine to anyone under 18, authorized its moderate use for those between 18 and 30, and for those over 40, prescribed no limits at all. Moreover, members of certain groups (judges and ship's helmsmen, for example, were to drink only water, lest alcohol dull their ability to think and act [Sournia]). Biblical references (including the Bible, the Quran, and the Talmud) are equivocal: on the one hand they describe alcohol as therapeutic, and on the other hand, condemn (and warn against) drunkenness: “Do not drink water any longer, but use a little wine for the sake of your stomach and your frequent cases of sickness” (1 Tim. 5:23); “Give strong drink unto him that is ready to perish, and wine unto those that be of heavy hearts” (Prov. 31:6); “Be not among winebibbers; among riotous eaters of flesh: For the drunkard and the glutton shall come to poverty: and drowsiness shall clothe a man with rags” Proverbs 23:20-21 (King James Version). Although the Old and New Testaments do not forbid alcohol use (and indeed prescribe the use of wine as a ceremonial and celebratory drink) these texts do link drunkenness with sinfulness (Jaffe, 1999). This general acceptance of moderate alcohol use and condemnation of alcohol abuse has persisted throughout the intervening centuries.

**Alcohol Use in Medieval and Renaissance Europe**

In early, medieval, and Renaissance Europe, men, women, and children consumed substantial amounts of alcohol on a daily basis. The folk wisdom that supported this practice probably did not mean that people recognized the role of the fermentation process in sterilization, but it is more likely to have been an outcome of ongoing custom. As English Literature and History specialist, Braswell notes: “The reason that people in medieval Europe so often drank ale, beer, and wine, is that the water was contaminated with raw sewage. They didn’t know molecular biology, but they knew that their drinking water was filthy” (Braswell,
cited in Short, 2001). The nutritional and social roles of beer, ale, and wine in substantial quantities was a well established practice, and maintenance allowances (e.g., for peasant labourers and for monks) are documented in numerous sources. Typical amounts in medieval times were two liters of wine daily, per capita (in France and Italy) and in England, a gallon of ale.

Alcohol had other approved uses in this era, as well, including medicinal; it was commonly used as a solvent for variety of chemical and herbal tinctures. Alcohol (almost always in moderation) was thought by some scholars to convey a variety of healthful benefits. For example, Andrew Borde, a Carthusian monk living in Reformation-era England, wrote several medical and dietary treatises; in 1542 he wrote Dyetary of Health, containing the following endorsement of alcohol:

Moderately drunken, it doth acuate and doth quicken a mans [sic] wits, it doth comfort the heart, it doth scour the liver; specially, if it be white wine, it doth rejuice all the powers of man, and doth nourish them; it doth ingender good blood, it doth nourish the brain and all the body. (Borde, cited in Martin, 1998).

Borde's mention of moderation in alcohol use is typical of the a clear demarcation between the moderate use of alcohol for sanitary, nutritional, social, and ceremonial reasons, which were generally approved, and drunkenness – which, long condemned by pre-Christian societies as well, was associated with moral weakness by the general population, and with the sin of gluttony by the Catholic Church.

Perceptions of Alcohol Use in the Modern Era

The perception of overconsumption as a moral weakness was transported from Europe to the Americas. In the 18th and 19th centuries the tendency to overindulge in alcohol is frequently described in terms of a problem of will. For example, in An Inquiry into the Effect of Ardent Spirits on the Human Mind and Body, a treatise written in 1784, U.S. physician and chief army medical officer Benjamin Rush noted: “Drunkenness is the result of a loss of willpower.
Initially drinking is purely a matter of choice. It becomes a habit and then a necessity” (cited in Sournia, 1990, p. 30.)

Prior to the 19th century in Canada, the regular use of alcohol was considered a social norm, and addiction to alcohol was largely ignored, with the exception of attempts by French and British authorities to regulate alcohol consumption by native people (Marsh, 1985). The amount of absolute alcohol consumed by Americans and Canadians in the 19th and 20th centuries has fluctuated, affected perhaps by reform movements such as temperance and prohibition, and certainly by social and economic trends. In the early 19th century, Americans were drinking on average seven (U.S.) gallons of pure alcohol annually; this amount had dropped by mid-century to about two gallons, when it began to rise again (Short, 2001). In Canada in the 1870s, average annual consumption was about 15 liters (Marsh). There were temperance and prohibition movements throughout the 19th and early 20th centuries in both Canada and the U.S. Prohibition laws were enacted in P.E.I. and Nova Scotia before World War I, and in all provinces during the war. The Prohibition Era (1920-1933) did not result in reduction in alcohol consumption, but did produce a brisk cross-border trade from Canada to the U.S., as liquor was still legally manufactured in Canada for scientific, industrial, religious, and medical purposes. Thus, if one were “ill” in Canada, it was possible to obtain a doctor’s prescription for alcohol. “Scandalous abuse of this system resulted, with veritable epidemics occurring during the Christmas holiday season” (Marsh, V. 1, p. 1491.) The “medicinal use” of alcohol has had a very long history, but the consideration of alcohol dependence as a disease is a more recent phenomenon – only arising within the last 200 years – and therefore constitutes somewhat of a break from the past.

More recent historical accounts identify two major breakthroughs in the shift to a disease perspective that came in 1935 and 1937, with Bill Wilson and Bob Smith’s founding of Alcoholics Anonymous, based on the recognition that alcohol dependence is a disease. Two
years later, Jellinek founded the Research Council on Problems of Alcohol, and subsequently defined "alcoholism" as a disease based on addiction (Hughes, 1989).

Despite the emphasis on a disease perspective throughout most of the 20th century, Hughes (1989) reviewed current perspectives on addiction and found that the moralistic perspective extended into the 1970s (Orcutt, 1976) and 1980s (Tournier, 1985). Additional examples of this purportedly outdated but persistent perspective may be found in the work of Fingarette (1988) and Peele (1989).

An alternative, contemporary perspective of alcohol dependence has been proposed by the social psychologist Stanton Peele (1998). His philosophical approach differs from both the moralistic perspective and the disease perspective in suggesting that addiction is a way of coping with life through artificially attaining feelings and rewards not achievable in other ways. Peele’s beliefs do not originate from academic or clinical research but from his personal observations that occurred in the 1960’s regarding compulsive relationships and drug use patterns that did not conform to popular stereotypes.

Explanatory Theoretical Perspectives of Alcohol Dependence

Some of the historical perceptions of alcohol use, which I have outlined in the foregoing section, provide foundations to support the explanatory theoretical perspectives that shape our understandings of alcohol use in the present day.

Several explanatory theoretical perspectives are found in the literature to address alcohol dependence. Rassool (1998) identifies these perspectives in terms of the moral, disease, psychological, and sociocultural models. Two more recent perspectives are the biopsychosocial model (Allen, 1996) that provides a broader and more holistic view of alcohol dependence not found in earlier perspectives and the newly emerging holistic model with an understanding of chronic disease and its implications to health and well-being (Ministry of
Health Services, 2004). In this section, I review each theoretical perspective, and provide a brief comment regarding the focus of treatment.

Alcohol Dependence Perceived as a Moral Failing

As a number of scholars have noted, the notion that alcohol dependence results from a moral defect owes much to a version of Christian morality based on biblical sources as described earlier. From this perspective, alcohol dependence is considered as an evil and the alcohol dependent person is thought to be a sinner, weak-willed, and lacking in impulse control (Flagler, Hughes, & Kovalesky, 1997; Hughes, 1989; Tomko, 1988). In this “moral defect” model, excessive use of alcohol is considered a willful act that results in intoxication and other sinful behaviors (Jaffe, 1999). The Canadian and American contexts are similar in that the philosophical underpinnings of the legal systems in both countries lie in this perspective of alcohol abuse as a moral failing. In each jurisdiction, this perspective has influenced the penal code such that public intoxication, for example, is considered a criminal offense in both countries (Starkey, 1986). As a result of condemnatory points of view that assign derogatory labels such as “drunk” and “addict” that only serve to shame and blame the “offender”, the individual is subsequently described as having a weak character and poor impulse control (Farnsworth & Bairan, 1990; Flagler, Hughes, & Kovalesky). Much of the stigma faced by individuals with a substance use disorder is based on this underlying moral model that labels anyone with a “bad habit” as a “bad person” (Brickman et al, 1982)

The moral perspective treatment focus is limited to directing the individual to exert sufficient willpower to abstain from drinking or taking drugs. The individual is considered to be personally responsible for his or her problem and hence the solution to the problem is the individual. The role of the health care professional, according to this model, is minimal and the
treatment is limited to reminding individuals that they are responsible for their problem and they, alone, must help themselves (Flagler, Hughes, & Kovalesky, 1997).

The Disease Perspective

As noted in the historical account of alcohol use, the disease perspective of alcohol dependence is one that many practitioners have come to accept. According to this perspective, addiction is a disease caused by genetic and biological factors (Jaffe, 1999). This perspective medicalizes drinking behaviours and its proponents also suggest that people who use alcohol to excess are powerless to control their consumption (Bandura, 1997). This model implies that the alcohol user adopt the role of an ill person; the health care provider views the client as having a disease (Rassool, 1998). As a disease condition, alcohol dependence is characterized by “cravings, compulsion, and quick loss of control” (Bandura, 1997, p.357). The disease perspective was adopted by the Alcoholics Anonymous association, with the concept of alcoholism as a disease stemming from the work of the researcher E. M. Jellinek in the 1960’s (Hughes, 1989). Jellinek (1960) identifies the core constructs of alcohol dependence as: (1) a predisposing characteristic body chemistry; (2) a condition that is progressive, incurable and that moves through identifiable stages; (3) an inability to control drinking once it has begun; and (4) requiring abstinence from all alcohol. The disease perspective advanced the study and understanding of alcohol dependence and has been the most influential in directing and shaping research and treatment programs in the modern era (Gordis, 2003).

The core constructs of the disease perspective are reflected in the commonly used language in the addictions field. The American Society of Addiction Medicine (ASAM) defines alcoholism as “a general but not diagnostic term, usually used to describe alcohol dependence, but sometimes used more broadly to describe a variety of problems related to the use of the beverage alcohol” (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003, p. 1602). The
American Society of Addictions Medicine (ASAM) and the National Council on Alcoholism and Drug Dependence (NCADD) define alcoholism as:

...a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. The disease is also progressive and fatal. It is characterized by continuous or periodical impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial (Morse & Flavin, 1992, p. 1012).

For terminology and definitions when establishing diagnoses in the clinical setting, researchers and clinicians now rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) to provide the official nomenclature that reflects extensive literature reviews by work groups sponsored by the National Institute of Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). In 1980, the term “alcoholism” in the DSM criteria was replaced by the two distinct categories: “alcohol abuse” and “alcohol dependence”, together with specific criteria to identify characteristics for each diagnosis. (These criteria have been superseded by the DSM-IV criteria, as outlined in the Appendix A).

Treatment strategies from a disease perspective are based upon the principle that individuals are not responsible for their problem behavior or the needed treatment. The health care provider’s role is to identify treatment options that address the underlying physiological determinants of the disease (Tomko, 1988). Integral to a disease model is the understanding that total abstinence from alcohol is necessary. This principle forms the basis underlying the philosophies of self-help groups such as Alcoholic Anonymous (AA). The treatment goal is to provide external supports since, without help, according to this model, the individual will be unable to control behaviours associated with alcohol dependence (Tomko, 1988).
The Psychological Perspective

The psychological perspective of alcohol dependence consists of principles related to social learning theory, family interaction theory, and personality approaches (Rassool, 1998). The social learning theory suggests that through observation and modeling, social behavior is learned. According to this perspective, the individual develops maladaptive ways of coping. In addition, proponents of this view consider the role of parents to be an important factor in early childhood in the way those who use alcohol at risk levels formulate coping strategies that eventually lead to patterns of at-risk alcohol use (Baer, Garmezy, & McLaughlin, 1987). Proponents of the psychological perspective also contend that, although some personality characteristics are associated with alcohol dependence, there is no evidence of an addictive personality type (Rassool).

Early psychoanalytic treatment approaches that did not acknowledge the biological determinants and the social factors associated with the disease were unsuccessful. The focus of more recent treatment approaches is upon learning behavior alternatives that offer an alternative to at-risk alcohol use or learning behaviors that are incompatible with at-risk alcohol use (Rassool, 1998).

The Sociocultural Perspective

The sociocultural perspective of alcohol dependence emphasizes the role of culture, beliefs, values, and attitudes held by the community in determining alcohol use (Rassool, 1998). This perspective suggests that cultural attitudes shape individual behaviour regarding the use of alcohol. Factors such as unemployment, social deprivation, and poor environment are believed to exert influences that lead the individual to start and continue to abuse alcohol (Peck & Plant, 1986). There are marked differences in the incidence of alcohol dependence across cultures and Bandura (1969) suggests the ways in which culture, ethnicity,
socioeconomic conditions, and occupational factors affect alcohol use vary according to different ethnic, national, and cultural contexts.

The sociocultural perspective incorporates treatment at two levels. At the macro level, the focus of treatment is on factors external to the individual. Thus, treatment will aim to address unemployment and social deprivation and improve social functioning (Boyd, 1993). At the micro level, treatment attends to low self-esteem and poor psychological functioning (Dembo, Williams, Schmeidler, & Wothke, 1993).

The Biopsychosocial Perspective

The biopsychosocial perspective of alcohol dependence defines a complex interaction between biological, psychological, social, and spiritual dimensions. More recent prevention, treatment, and research initiatives proceed from this perspective (Allen, 1996). Each of the components of the term “biopsychosocial” represents a component of the theoretical framework for this perspective. Thus, “bio” represents the biological factors which underlie the brain chemistry problems found with dependence; “psycho” represents the deeply entrenched habits related to the process of perceiving, thinking, and feeling and “social” represents the extent to which society and social constructs affect problems that develop in the workplace and in social and intimate relationships. The biopsychosocial perspective claims that alcohol dependence is not a distinct condition but a multi-dimensional behavioral pattern. This perspective, which has its origins in aspects of earlier models, provides a broader holistic framework to address alcohol dependence; moreover, it challenges “monolithic” views of alcohol dependence by suggesting there are numerous factors that contribute to the development of alcohol problems (Bandura, 1997, p. 357).

Treatment from a biopsychosocial perspective shifts the choice of treatment goals from the “top down” mandated approach in the traditional disease perspective; instead, the
individual selects from a choice of options (Allen, 1996). Treatment replaces confrontation and enforcement of abstinence, as the traditional disease perspective purports, and places a choice of treatments in the hands of the patient. The aim of treatment from this perspective is to meet the patient “where they are at” and to consider the stages of behavior change. In common with the disease perspective, the biopsychosocial perspective tends to reject the use of medication in treating addictions.

A Holistic Model

The newest model that offers a perspective from which to consider alcohol abuse and alcohol dependence has only recently begun to be applied to practice settings. This perspective adopts a holistic approach to health and well-being to contextualize treatment planning for at-risk alcohol use (Ministry of Health Services, 2004). The model incorporating holistic approaches to chronic disease management, but also incorporates the strengths of some earlier models. Proponents of this model recognize that an essential element of disease management is active participation by individuals in self-management, treatment, and recovery activities. Treatment options are focused on motivational techniques, brief intervention, consumer education, cognitive-behavioral therapy, and pharmacology. Acupuncture, meditation, and stress management are further treatment options. Patients are seen to be competent in managing their lives, and are given access to information and support. The holistic model is consistent with a public health approach (Ministry of Health Services) that emphasizes the reduction of problem consequences or harm reduction.

In view of the various explanatory theoretical perspectives that persist in the literature, it is apparent that no single viewpoint has succeeded in providing a definitive, convincing, and unanimously accepted explanation for alcohol abuse and dependence (Rassool, 1998; Allen, 1998). Originating from these differing theoretical perspectives is a proliferation
of models for treatment planning, which, as Shaffer (1990) asserts, vicariously guide interventions and treatment approaches in determining how, when, and where clinicians intervene. Cannon and Brown (1988) suggest that one thing remains clear, in all the available models: whether the problem is defined in “medical or moral terms, the solution is believed to lie in changing defective individuals rather than changing defective institutions or social structures” (p. 96). The influence of the moralists, it seems – even if subtly so, in some models – remains remarkably persistent.

Substance Abuse, Alcohol Abuse and Alcohol Dependence: Nurses’ Attitudes

As members of society, nurses are inevitably exposed to societal myths, beliefs, and biased attitudes regarding alcohol abuse and alcohol dependence; once adopted, these are not easily effaced by education and training. According to Gusfield (cited in Cannon and Brown, 1988), public problems have both a “cognitive component explaining the nature and cause of the problem and a moral component calling for eradication of the problem phenomena” (p. 96). Singer (1986) states “alcoholism and drug addiction are defined both in medical terms as a disease to be treated by health professionals, and in moral terms as character flaws or even crimes to be controlled by police and courts” (p. 114). Despite the newly emerging perspectives that provide a more holistic and complex view of the phenomenon than the moralists offer, the perception of nurses with respect to alcohol dependence and abuse, tends mainly to reflect one of these two dominant perspectives.

Nurses’ Perceptions of Alcohol Dependence as Affected by Myths, Beliefs, and Biases

In my search of nursing textbooks, I found a number of myths regarding alcohol dependence. Mathre (2000) identifies some myths as: “an alcoholic is a skid road bum”; “if you teach people about drugs, they will abuse them”; and “addiction is a sin or moral failing” (p.
Sullivan (1995) also identifies some further myths as: "people just think they're addicted to alcohol or drugs. They could quit if they had more willpower", and "alcoholics (or addicts) must want to quit before anything can be done to help them." Mathre suggests that when myths remain unchallenged there is a potential for them to affect attitude formation. Although both Sullivan and Mathre refute the various myths with explanations and statistics, their references are not identified or subjected to empirical scrutiny. Such myths may serve to perpetuate misperceptions and misinformation about the process of addiction, promote stereotypical thinking, and support a negative and pessimistic attitude toward those who use alcohol at risk levels (Sullivan).

Nurses' Attitudes Towards Substance Abuse

McLaughlin and Long's (1996) review of mainly British and American literature examined health professionals' perceptions of illicit drugs and their clients who use them. When health care professionals maintain a negative perception of clients who use illicit drugs, they tend to stigmatize the client. McLaughlin and Long found that health care providers perceived the drug-using client as "tainted", as having "weak" personality traits, and as having a "failing in character" that resulted in the client being a "threat to society" (p. 284). The study summarized the experiences of health care professionals who cared for drug-using clients as "the most negative, unrewarding, and unpleasant experience of their clinical careers" (p. 285). An outcome of such a negative attitude, these scholars suggest, is "inappropriate care" that "makes change almost impossible" (p. 286). Such judgmental responses to substance-abusing clients appear to reflect the perspective of addiction as a moral defect.

An Australian research study by Happell, Carta, and Pinikahana (2002) addressed the lack of emphasis in nursing education on improving nurses' knowledge, attitudes, and skills related to substance use. The nurse participants (n=134) completed a survey questionnaire and
the data was analyzed using the Statistical Package for Social Sciences (SPSS). The findings revealed that, overall, nurses had adequate levels of knowledge and problem solving abilities regarding alcohol and other drug use. What these researchers found to be lacking, was nurses' knowledge of safe drinking guidelines, management of clients with dual-disorders, and education regarding substance withdrawal. Positive attitudes towards substance use were expressed and almost all of the respondents wanted to know more about drug and alcohol issues and planning nursing care.

Raeside (2003) conducted a research study in Scotland to investigate the influence of education and experience on the attitudes of neonatal nurses/midwives when caring for mothers and infants affected by substance abuse. The participants (n=50) completed a self-report questionnaire that was analyzed through comparative analysis. The low knowledge score reflected deficits in knowledge of substance abuse. The findings indicated that a majority of the participants experienced anger towards drug-using, pregnant woman. An interesting finding was that participants with more than five years’ experience had the most negative attitudes, and participants with less than two years’ experience had the least negative attitudes. Based on their findings, the researchers recommended that education be aimed at the needs of both the junior and the senior staff.

In general, the literature reflects apparent deficits in nursing education not only in providing sufficient knowledge to guide nursing practice with respect to substance abuse, but also in countering prevailing negative attitudes and biases towards those who are using substances at risk levels.

**Nurses’ Attitudes Towards Alcohol Abuse and Alcohol Dependence**

Over the last three decades, nursing studies that address nurses’ attitudes toward alcohol abuse and alcohol dependence have been conducted by American, British, and
Australian researchers. There is a paucity of research-based accounts addressing the topic from a Canadian perspective. The research that has been published has been of a quantitative design and these studies examined attitudes of health providers towards alcohol-dependent clients.

Wallston, Wallston, and DeVellis's (1976) experimental study (n=40 medical/surgical nurses) at an American university-affiliated hospital investigated the effects of labeling a simulated patient an "alcoholic". An imaginary patient was described to 16 nurses as having a diagnosis of alcoholism and gastric ulcer. Eight other nurses did not receive a diagnosis. The remaining eight participants were in the control group. The participants rated the patient on a scale designed to rate affective meaning underlying the concepts held toward the patient. Twelve audiotaped statements relevant to the physical and psychological condition of the simulated patient were played to the experimental group and one of the two control groups. The unlabeled patients were rated significantly more positively on the Evaluation (good-bad, nice-awful) and Social Stimulus (self-reliant-dependent, understandable-confusing) factors, and significantly lower on the Activity (active-passive, fast-slow) factor, than the patient labeled an "alcoholic". The findings of the study determined that the nurses viewed the hypothetical patient without a label much more favorably than either the same patient when labeled an "alcoholic" or the stereotypic patient with "alcoholism". When the patient was labeled an "alcoholic", he was rated as unreliable, dependent, and uncooperative. The results of the study support the view that stereotypes exert a powerful influence over nurses' impressions of alcohol dependency. A limitation of the study is the non-random selection process.

Reisman and Shrader (1984) investigated industrial nurses' attitudes towards employees with alcohol abuse problems and their referral rates to subsequent treatment. The participants of the study (n=32) were employed at the Ford Motor Company Rouge Complex and all were given a questionnaire that measured attitudes, knowledge, and experiences. Participants were divided into high and low referral groups. The survey was based on two tools
with established validity and reliability. The hypothesis, which was not supported, stated that there would be no relationship between nurses’ attitude and their referral rates. The correlation between composite scores and number of referrals was .54. Of the low-referral group, nearly one-quarter identified a knowledge deficit for detecting alcohol dependence. More than half of the high-referral group believed that alcohol dependence results from physiological problems and low-referral nurses were more likely to identify lack of will power and physiological predisposition and etiologic factors. The belief that alcohol dependent individuals had a poor prognosis was more common with low-referral rate nurses than high-referral rate nurses. The study revealed that the low referral rate nurses possessed stereotyping attitudes identified in other research studies. The high-referral rate nurses had more personal experience with alcohol dependent persons and had cared for more alcohol-dependent individuals on the job. The authors were unable to determine if personal experience gave the nurses skills to recognize the potentially alcohol dependent individual on the job or if personal experience resulted in a more open and positive attitude toward alcohol dependent employees. The study’s findings, that with more hands-on experience, nurses made more referrals, are consistent with other studies indicating that nurses’ attitudes influence their behavior. A limitation of the study is that the tool lacks established reliability and validity.

Sullivan and Hale (1987) investigated registered nurses’ beliefs about alcohol dependence and the alcohol-dependent client and compared these beliefs with the subjects’ biographical and professional variables. The participants (n=1,027) of this national study were members of the American Nurses’ Association and were randomly selected from a sample of 3000 individuals. A two-part questionnaire was used for data collection to assess the conceptual dimensions of beliefs about the etiology of alcohol dependence, the appropriate treatment approach, and the degree of social stigma or acceptance. The researchers found that the participants’ held strong beliefs that alcohol dependence has either a psychological or
physical-genetic cause (or both) and that alcohol dependence should be treated as a medical illness. Few subjects believed that alcohol dependence was a moral weakness or that alcohol-dependent individuals should be socially rejected. Attempts to associate participant demographic characteristics with either a positive or a negative belief about alcohol dependence found few such associations. Education, gender, and locale (urban or rural settings) were associated with differences in beliefs and those differences were relatively minor. No differences were found based upon clinical specialty, type of employing institution, position held, or state or region of the country in which the respondent lived. The findings of the study indicate a more positive set of beliefs about alcohol abuse among participating nurses than previous research indicated; however, the researchers suggest that this may be due to differences in methodologies. Limitations of the study include the low response rate and possible positive response phenomena.

Rowland and Maynard (1989) investigated British hospital nurses' (n=46) attitudes toward screening patients for alcohol-related problems, their knowledge of what constituted harmful drinking, and their views on alcohol education for those at risk of harming their health. This prospective study followed nurses' participation in an early identification and patient education program. The program included reading material on the nature and extent of problem drinking, information on the benefits of early intervention, and training in the use of a brief Alcohol Screening Questionnaire. The participants were also shown a 10-minute program on “drinking sensibly” and given a booklet. The nurses completed an evaluation questionnaire following their participation in the patient-screening program. When admitting a patient, 53% of the nurses requested information on alcohol use, although 59% of the nurses thought it was important to screen patients for at-risk alcohol use. Nurses were found to be generally aware of recommended limits of alcohol use. Further findings from the study revealed that nurses were informed about health and social problems associated with at risk alcohol use. Nurses were
found to understand that at-risk alcohol use is a universal concern and not restricted to social class, employment status, marital status, or gender. Although over 50% of the nurses reported that they questioned patients regarding at-risk alcohol use and 59% of the nurses agreed that it was important to screen for at-risk alcohol use, only 68% of the nurses felt that alcohol dependence was probably or definitely a disease. Eleven percent of the nurses rejected the disease concept of alcohol dependence. From their findings, these authors concluded that a sizeable proportion of the nurses remained unconvinced of the long-term benefits of education for those who drink to excess. Limitations of the study were the lack of information on the specifics of the questionnaire, the small sample size, and the lack of control/intervention group.

Cannon and Brown (1988) investigated nurses’ attitudes toward “substance abuse, substance abusers in general and impaired nurses in particular”. The researchers obtained a systematic probability sample of registered nurses (n=396) from the Oregon State Board of Nursing. The study used three instruments to collect data. The “Substance Abuse Attitude Survey” (SAAS) measured the attitudes of health professionals regarding various aspects of alcohol and drug use. The subscales investigated permissiveness, non-stereotype, non-moralistic, treatment intervention, and treatment options. The 42-item Likert-type instrument was developed by Chappel, Veach, and Krug (1985) and has established reliability. The researchers found 98% of the nurses subscribed to the disease concept of alcohol dependence. Although the respondents indicated that it was treatable, it was not considered curable and required continuous monitoring leading to the conclusion that the attitudes of the nurses were generally supportive toward substance abuse and abusers. However, the wide range of scores with many of the scores falling below the scale’s neutral midpoint suggested many individuals were negatively inclined toward substance abusers in general. The researchers concluded that the respondents viewed substance abuse as both a disease and a moral blemish. In measuring nurses’ attitude toward impaired colleagues, the researchers found a generally positive attitude;
this finding constituted a shift from earlier findings that had indicated nurses had negative attitudes towards substance abuse. Although 76% of the respondents suggested they would confront a substance-abusing colleague, the researchers suggested this figure seemed high based upon the findings of earlier research. In examining nurses' characteristics in relation to attitudes, considerable variability was found in the scores from the Substance Abuse Attitude Scale. Years of employment were the most important consideration, followed by education. Participants employed for a longer period were less favorably inclined toward substance abusers, and those with baccalaureate or higher degrees were more favorably inclined toward substance abusers. In conclusion, the researchers suggest that nurses did not subscribe to the disease concept of substance abuse and did not approve of treatment interventions; many nurses appeared to hold non-therapeutic attitudes toward alcohol-dependent clients and those that use drugs. A lack of prognostic optimism (or the presence of pessimism) is linked with other negative attitudes and reluctance to address impaired peers.

Cooper's study (1994) reported on a national British survey conducted to determine registered nurses attitudes and level of therapeutic commitment to patients with alcohol-related problems. The participants (n=347) completed an abridged version of the “Alcohol and Alcohol Problems Questionnaire” (Anderson & Clement, 1987). The questionnaire assessed therapeutic attitudes and found that 30% agreed to being satisfied in working with clients with alcohol-related problems (ARPs). Nineteen per cent agreed that it is rewarding to work with clients with ARPs and 83% agreed that they were interested in the nature of ARPs and the responses that can be made. Eighteen per cent agreed that they would work with clients with ARPs. Nurses answered 38% of questions about alcohol-related problems correctly. Two-thirds of the nurses felt that they did not know how to counsel the problem drinkers. Limitations of the survey were the non-probability sampling procedure and the risk of bias.
Allen (1993) studied nurses' attitudes (n=66) toward alcohol-dependent patients at a community hospital in the United States. In order to identify differences between community and urban settings, the findings were compared to a focus group discussion conducted at a large university hospital. The head nurses on each of the 10 units chosen to participate in the study distributed the questionnaire to 10 nurses working on their units. The Marcus Alcoholism Questionnaire (Marcus, 1963) was used to collect data and included questions to address emotional difficulties, loss of control, prognosis for recovery, and alcoholism as a disease. The questionnaire has been used by professionals from various disciplines and has an established validity and reliability of .90. High scores were obtained for factors that identified: (a) emotional factors as being important causes for alcohol dependence; (b) alcohol dependent individuals as unable to control their drinking; (c) the alcohol-dependent patient as a steady drinker; and (d) the belief that alcohol is a highly addictive drug. Some of the factors that received a low score, indicative of a negative attitude included: (a) the belief that most alcohol-dependent patients do not recover; (b) alcohol-dependent clients are weak-willed; (c) alcohol dependency is not an illness; and (d) most alcohol-dependent patients come from the lower classes of society. The study found the positive attitudes of nurses toward the alcohol-dependent patients at the community hospital contrasted significantly with the negative attitudes of the nurses at the university hospital. The rationale for this difference was thought to be the existence of a inpatient alcohol and drug treatment program, in-service education, and nurses involved in providing consultation services throughout the hospital. Data collection for the university hospital nurses consisted of a focus group using unstructured interview techniques in which the nurses expressed little patience, lack of knowledge, as well as feelings of disgust, anger, and of “being used” when dealing with the alcohol dependent patient. The researchers identified the role of education in developing a positive nurse attitude and the building of a therapeutic client relationship.
Happell and Taylor (2001) investigated nurses employed at a large, private medical-surgical hospital in Melbourne, Australia to ascertain the effect of specialist consultation and liaison services in improving the attitudes of general nurses towards clients with alcohol-related problems. The sample (n=106) was randomly selected from general nurses employed at the hospital. The questionnaire designed specifically for this study consisted of 50 statements using a 6-point Likert Scale. Measures were undertaken to ensure the validity and reliability of the instrument through bio-statistician supervision and nurse expert input and review. The tool collected demographic data and information regarding the utilization of liaison alcohol and drug services. The tool also measured attitudes, confidence, and perceived knowledge in relation to the client care. The findings indicate a slightly positive range for attitudes and neutral responses for confidence and perceived knowledge in caring of clients. The participants that used the drug and alcohol liaison service scored only slightly higher on attitudes, confidence, and perceived knowledge scales. In contrast to Allen’s (1993) study, which suggested that inpatient alcohol and drug treatment programs did possibly influence the attitude of the community hospital nurses, the findings of this study did not have a similar result. The slightly positive range of attitudinal responses suggests a shift from distinctly negative attitudes found in past studies.

Howard and Chung (2000) completed a critical analysis of survey design studies published over the last three decades that investigated nurses’ attitudes regarding substance abusers. The following conclusions emerged: (a) nurses’ attitudes towards substance misusers are more positive than they were a decade ago; (b) recent reports reveal greater acceptance of substance misusers; (c) younger nurses are more likely than experienced nurses to express positive views toward substance misusers; (d) an attitude of “non-permissiveness” remains toward personal and societal alcohol and drug use; (e) a significant minority of nurses continue to stereotype alcohol and drug misusers; (f) patients perceive prognostic pessimism on the part
of nurses; and (g) negative attitudes toward substance-abusing patients may contribute to a lack of diligence in their case-finding efforts on the part of many health care providers (p. 362). Individual nurses’ attitudes were related to age, gender, ethnicity, and religious beliefs and must be considered in the context of cultural settings and historical eras (p. 363). These researchers suggest that more complex analytical strategies may be required to further our understanding of the relationship between attitude and behavior when considering the substance misusing population.

Discussion

It is apparent from the historical account of perceptions of alcohol use that certain traditional, moralistic values, dating back to antiquity, are intricately interwoven into our current thinking. It is somewhat surprising, however, to consider the extent to which these values continue to influence present-day theory and practice. Clearly, certain myths, beliefs, and attitudes associated with alcohol abuse and alcohol dependence, persist such that the attitudes of nurses may reflect these negative biases. It is important to consider the research that demonstrates that these negative attitudes continue to affect nursing practice (although the trend appears to be that nurses’ attitudes are becoming somewhat less negative), along with that fact that patients using alcohol at risk levels frequently remain undetected and untreated as high-risk users. This suggests that we need to gain a better understanding of the extent to which traditional moralistic values influence attitude formation among nurses despite attempts to counter these in nursing education.

In reviewing the literature, I found that two significant gaps in knowledge are apparent. One gap relates to the lack of research from a Canadian perspective that is sensitive to the Canadian health care system. Health care services concerned with alcohol abuse and alcohol dependence vary considerable between geographical areas, so this lack of a particularly
Canadian component is an important one for nursing researchers in Canada to consider. A second gap relates to the lack of research literature using a qualitative research design; as I note above, most of the extant research consists of quantitative research designs. Studies that use a qualitative research design have the potential to develop a richer and fuller understanding of research phenomena than quantitative design (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). The qualitative, interpretive descriptive study I have undertaken and describe herein is a step towards toward addressing these two gaps in the literature.

Summary

The historical account of perceptions of alcohol use demonstrates the continuity of moralistic attitudes and beliefs about alcohol use that extend from antiquity to the present day. For millennia, despite the fact that men, women, and even children traditionally consumed large amounts of beer and wine on a daily basis (until the advent of the modern era), the biblical censure of “drunkenness” has pervaded European thought and influenced social and civil policy. This ambiguity about alcohol has remained with us into the modern era: among North Americans, the vast majority drinks socially, many have a negative bias toward those who are alcohol-dependent, and a substantial proportion of Canadians – nearly ten percent – reportedly has a problem with drinking.

Negative perceptions about alcohol are intricately interwoven into not only our current thinking but also into present-day nursing practice to a considerable extent, as the research points out. Some explanatory theoretical perspectives, including the moralistic and psychological perspectives, also reflect certain of these historical, traditional attitudes toward alcohol dependence. Other new and emerging theories and models, however, offer different perspectives on the phenomenon and the way it may be considered from a health care perspective.
Researchers have investigated nurses’ attitudes toward substance abuse, alcohol abuse, and alcohol dependence, and in general have found these to range from very negative to somewhat negative, although a few recent studies found that nurses had more positive attitudes than previously determined. One overall trend was that nurses with less experience tended to have more positive attitudes than those with more experience, and other trend was that nurses’ attitudes appear to be moving towards the positive.

The research studies reviewed were of a descriptive quantitative design with the exception of one experimental design. Sample selection methods varied from random to non-random processes. The data collection processes involved application of questionnaires, checklists, rating scales, and focus group. For the majority of the studies, data collection involved survey questionnaires.

The gaps identified in the literature relate to a dearth of qualitative studies that explore nurses perspectives towards alcohol abuse and dependence, and studies that investigate this phenomenon from the Canadian perspective that are sensitive to issues in the Canadian health care system.
CHAPTER 3: METHODOLOGY

A qualitative method was used for this study for several reasons. First, although numerous quantitative designed research studies have addressed nurses' attitudes associated with alcohol abuse and alcohol dependence, few studies have addressed the topic from a qualitative perspective. Burns and Grove (1997) describe qualitative research as a means of exploring the depth, richness, and complexity inherent in a little known phenomenon (p.67). A richer understanding of nurses' meanings and understandings associated with alcohol abuse and alcohol dependence is needed to provide insight into that which is not obtainable from surveys or other linear measures of perceptions, and one of the aims of this study was to address the dearth of qualitative analyses in the literature. Second, in view of the complex and often emotive nature of issues related to at-risk alcohol use and alcohol dependence, the qualitative research methodology facilitates the emergence of diverse viewpoints to address the research question, and offers a means to develop analysis that can lead to practice-based knowledge. I used direct quotations from the participants to provide rich descriptions of the phenomenon under investigation, and to enable the reader to understand the participant's perspectives. My intention was to develop a fuller meaning and understanding of the phenomenon; such an understanding is not necessarily achievable through traditional, quantitative research methods. Finally, the chosen design, interpretive description, unlike other qualitative methodologies, has been developed in a nursing context specifically to enable nurse scholars to investigate phenomena of interest to clinicians and to generate practice knowledge for nurses. Thorne, Reimer Kirkham, and MacDonald-Emes (1997) originally conceptualized and developed this method, and it is seen to be a departure "from the specific methods dominating qualitative nursing research at the time, and reflected the evolution of qualitative methodology with the disciplinary domain of nursing" (Thorne et al., 2004, p. 17). Thus, the qualitative method and
interpretive descriptive research design are well suited to nursing research that explores psychosocial phenomena in the clinical context.

Research Methodology

The interpretive descriptive approach provides "a logical structure and philosophic rationale for the design decisions made in qualitative inquiries" (Thorne et al., 2004, p. 3). Sandelowski notes that interpretive descriptive design "has found a place in the lexicon of nursing research methodologies" (2000, cited in Thorne et al., p. 3). The aim of interpretive descriptive inquiry is to investigate human phenomena and analyze the data obtained through inductive analysis such that the themes that emerge may inform clinical understanding of the phenomenon of interest. This methodology allowed me to move beyond descriptions of the nurses' experience and engage in interpretation of the nurses' experiences.

The philosophical underpinnings of naturalistic research inquiries (such as interpretive description) have been set out by Lincoln and Guba (1985):

(1) There are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed, and ultimately subjective.

(2) The inquirer and the "object" of inquiry interact to influence one another; indeed, the knower and the known are inseparable.

(3) No a priori theory could possibly encompass the multiple realities that are likely to be encountered; rather, theory must emerge or be grounded in the data (cited in Thorne et al., 2004, p. 5).

Sandelowski and Barrosso (2002) caution that it is essential to make explicit, in the final representation of the interpretive description, the analytic processes whereby the researcher interprets the collected data and develops the findings. Thus, I have described the analytic and interpretive method I used and have followed this framework throughout the study analysis and interpretation. Finally, research of this design is to have clinical applicability: the products of interpretive description are to constitute a "tentative truth claim" about what is
common within a clinical phenomenon" (Thorne et al. 2004, p. 7). I aimed at ensuring that the interpretive products of this study, while making claims only to a constructed and subjective “truthfulness,” nevertheless will be relevant, useful, and thought-provoking for clinicians, and will provide the impetus for further dialogue among nursing researchers interested in the phenomenon under investigation herein.

Sampling Technique

To gather the data for this study, I chose a purposive sampling technique. Although a qualitative study does not entail an a priori decision with respect to sample size (Patton, 2002, p. 244) I had anticipated a sample size of eight to ten, and I elected to cease data collection after nine participant interviews as I noted that a repetition of content occurred and the flow of new information had stopped. I obtained a sample of nine participants who met the study criteria.

Selection Criteria

The selection criteria I set for participants were that each participant:

1. be a practicing medical or surgical nurse working full or part-time in a medical, surgical, orthopedic, or neurological unit;
2. have a minimum of experience in nursing of one year;
3. be willing to participate in the study; and
4. have knowledge of the phenomenon under investigation.

The participants needed to have a least a year of experience in nursing to ensure that they would likely have experiences to relate with respect to nursing clients who were using alcohol at risk levels, and thus would be able to provide information about the phenomenon.
Context of the Clinical Agency

The clinical agency in which the research participants practiced is located in a geographic area that has a high standard of living in contrast to some other areas of the Lower Mainland to which the study participants refer. The visible signs of alcohol abuse and alcohol dependence more commonly observed in poorer socio-economic areas are seldom observed in the area in which this study occurred. There is an implication that this clinical agency is located in a more affluent area of the Lower Mainland. All participants practiced from this clinical agency.

Recruitment Process

To begin the recruitment process, I distributed a letter describing the study (Appendix C) to the Unit Managers of medical, surgical, orthopedic, and neurological units in an acute care hospital in the Vancouver region. In the letter, I asked the manager for permission to attend the nurses' unit staff meetings. This strategy was unsuccessful, as I was unable to make the necessary contact with Unit Managers, who did not respond to these requests. The reason for this lack of response are speculative; however, given the large portfolios of nurse managers today, it is perhaps likely that the managers were unable to respond because of overly heavy workloads. In such a case, unfortunately, requests for cooperation with nursing research may have to take a back seat to patient and nursing needs. Relying on my alternative sample collection strategy, I then distributed copies of an invitational letter (Appendix D) in areas where the potential participants congregated such as staff lounges, and also placed posters that described the study (Appendix E) in these areas. By this means, I was able to obtain a sample suitable for the purposes of this study.
Description of the Participants

The nine nurses who participated in this study represent both medical and surgical practice areas. Each participant completed a demographic questionnaire (Appendix F). The most striking demographic fact about the participants in this study is the vast amount of accumulated nursing experience they possess in medical and surgical areas. The participants’ average number of years in nursing was just under 25 years and the average number of years in the medical and surgical areas was over 19 years.

I solicited information about the ages of participants by asking them to specify only an age range; one participant was in the 20-29 years age range, one was in the 30-39 years range, three were in the 40-49 years range, and four were in the 50-59 years range. All participants were female. All participants were originally educated in the diploma RN program and one participant had completed a BSN degree.

Data Collection and General Characteristics of the Interviews

I obtained consent from the participants before initiating any data collection procedures; all participants signed and returned the informed consent form (Appendix G). To facilitate the interview process, I developed an interview guide (Appendix H) in consultation with committee members. The guide included “grand tour” questions to provide a broad and non-threatening opening in the interview and “mini-tour” questions designed to encourage the participants to explore and describe their meanings and interpretations attributed to alcohol abuse and alcohol dependence.

For this study, data was generated through open-ended inductive interviewing techniques. Prior to the interviews, the participants received a copy of an introductory letter that described the purpose of the study and provided a brief overview of the research.
was collected using audiotape for the interviews; a transcriptionist transcribed the resulting audiotape recordings verbatim. I interviewed all the participants in person, at a time convenient to both the participant and myself. No problems or significant interruptions occurred during any of the interviews. I spent some time initially in establishing a sense of rapport with each participant. During each interview, the participants openly shared their experiences as medical and surgical nurses who had given nursing care to patients who were potentially affected by alcohol use.

To further enrich the data, I kept field notes documenting environmental circumstances, participant characteristics, nonverbal behaviors, affect, communication processes, rapport, power dynamics, impressions, and any problems that arose (Mishler, 1986). The open-ended interviews were based on the assumption that meanings, understandings, and interpretations cannot be standardized (Denzin, 2001) and that each participant would have a unique story to share.

Data Analysis

Interpretive description entails an inductive method for data analysis; this analysis begins with the collection of the first datum and occurs simultaneously with the data collection. The inductive analytic process requires creativity, sensitivity, and insight (Morse & Field, 1995; Thorne et al., 2004) and is a means whereby the researcher can articulate themes and patterns in the data and make interpretive choices. The analysis is an iterative process in which the data and the evolving interpretation inform one another (Thorne et al.).

Following each interview, I recorded field notes; these were a useful source during analysis and helped to enrich the data. Once the interviews were complete and had been transcribed, I listened to each tape while reviewing the transcripts to ensure the latter accurately captured the interview data. I then re-read the interview transcripts and began to
identify potential themes, sub-themes, and emerging patterns. I then used constant comparative analysis, a process of discovering similarities and differences in the data, and of grouping the data thematically. Through this analytic process, I developed a foundation for the interpretive product of the analysis and a coherent description of the phenomenon (Lincoln & Guba, 1985). The aim of this analysis was to attempt to illuminate the phenomenon in a meaningful way, and perhaps even to shed new light on the familiar.

Rigor

Lincoln and Guba (1985) and Sandelowski (1986) are among the scholars that have produced guidelines for naturalistic inquiry, suggesting that trustworthiness, applicability, consistency, transferability, auditability, and neutrality are necessary for rigor. However, there has been a recent move among qualitative research theoreticians and scholars to acknowledge certain important attributes of qualitative research, and to privilege these over credibility claims based on, for example, an “audit trail”. Some of the attributes of qualitative research that many scholars now emphasize as important for credibility and rigor are openness and Emden and Sandelowski’s (1999) ‘criterion of uncertainty’ that “acknowledges a certain tentativeness about the final research outcomes” (cited in Thorne et al., 2004). Caelli, Ray, and Mill stress the need for transparency in the research process, “particularly as it pertains to relations of power, the intersubjective construction of knowledge, and the positioning of the researcher” (2003, cited in Thorne et al.).

As nursing scholars are now asserting, rigor in interpretive design depends on the researcher’s awareness of his or her role as interpreter and as an essential generator of “findings” that have “interpretive authority” (Thorne, 1997). Sandelowski and Barosso (2002) exhort researchers to undertake the “risk” of making an interpretation; Thorne et al. (2004) caution that asserting ownership of one’s interpretation can be one of the most difficult aspects
of the interpretive descriptive method. Moreover, transparency is now understood to be essential for credibility and rigor. Thus, it is not the purpose of interpretive description to offer new "truths", nor to theorize; these are the projects of other qualitative methods, which, for example, seek to offer an "interpretive explanation". Rather, in this interpretive description I attempt to present as a "constructed truth" a coherent description of thematic concepts and patterns that both characterize the phenomenon under investigation but also account for variations within it (Thorne et al., 2004). To do this, I have first posed questions about the phenomenon, then reconceptualized and reinterpreted the collected data to arrive at an understanding that, while new, is instantly recognizable to and resonant for clinicians. As Thorne et al. note, "the best interpretive descriptions pass what has been referred to as the 'thoughtful clinician test,' in which those who have expert knowledge of the phenomenon in a particular way find that the claims are plausible and confirmatory of 'clinical hunches' at the same time as they illuminate new relationships and understandings" (Thorne et al., p. 17).

**Ethical Considerations**

I obtained ethical approval for this research from the University of British Columbia and the clinical agency. Research protocols ensured confidentiality, anonymity, and privacy of the participants. The transcriptionist signed a confidentiality agreement. All data collected, including the audiotapes of interviews and the verbatim transcripts, were treated as confidential and kept in a locked and secure filing cabinet at my place of residence. The computer-based data (transcripts and analysis of transcripts) have been kept on a password-secured file on my home computer. Back-up computer files have been kept on disc and stored in a secured locked filing cabinet at my place of residence. Before the audiotapes were submitted to the hired transcriptionist, all identifying information was removed.
All participant interviews have been conducted during the participants’ own free time and at a mutually agreed upon location. At the initial meeting, the participants were given a verbal explanation of the purpose of the study. A written consent to participate in the study was obtained. The participants were advised that they were not required to participate in the study, and that their decision to participate will have no bearing on their employment status. The participants were also informed that they could stop the interview at any time and could refuse to answer any questions. To further ensure confidentiality and protect the demographic data, each participant was assigned a participant number that has been documented and stored separately from the transcription data. The participants were given a copy of the informed consent form that included:

1. a brief overview of the proposed research study;
2. a list of the rights of participants;
3. a list of expectations of the research participants;
4. measures identified to ensure confidentiality; and
5. a list of names and phone numbers of a contact person should they have any questions.

Although there may be no direct benefit in participating in this study, it was presumed that the participants would gain satisfaction in knowing that their participation in the study has advanced nursing knowledge.

Limitations of the Study

A possible limitation of the study may have occurred based upon the participants changing their responses due to personal bias, anger, politics, and simple lack of awareness (Patton, 2002). The subject matter is such that participants may have been hesitant to disclose some opinions and feelings for personal reasons, a positive response phenomena may have
occurred. For example, participants may have been reticent to disclose their true feelings, for fear of being identified as judgmental or intolerant and possessing attitudes and qualities that would appear non-therapeutic; a further fear may be related to being viewed as incompetent in their nursing practice.

Although there was no intention to restrict the gender of participants, the fact that only female participants were recruited may constitute a limitation of this study. Considering the research question from a male perspective may have added a further dimension to the interview data. A limitation to the generalizability of the study may occur as a result of the majority of the participants being representative of the age ranges 40-49 and 50-59; their nursing education curriculum may not have included information about addictive disease to the extent of the more recent nursing curriculum. A final limitation may have occurred based upon the researcher having had practice experience in the medical and surgical areas.

Summary

This qualitative study examines the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses in a Canadian acute care tertiary hospital. The nine study participants were obtained through purposive sampling, and were practicing nurses in the medical and surgical units of an urban hospital. Data was generated through semi-structured interviews with open-ended questions, and analyzed inductively using an interpretive descriptive approach. I have made every effort to ensure rigor in my data sampling, collection, and analysis, and to preserve transparency in the presentation of the findings. The themes and sub-themes that have emerged in the course of my analysis offer insight into the experiences of nurses who care for patients who are using alcohol at risk levels.
CHAPTER FOUR: FINDINGS

The findings presented herein relate to the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses. The participants described their experiences when screening for at-risk alcohol use, assessing patients, and providing nursing care to alcohol-dependent patients. As the literature suggests, nurses tend to bring the meanings and interpretations they attribute to alcohol abuse and alcohol dependence — acquired as a result of personal, as well as professional, experience — to their practice; that is, the nursing professional’s beliefs and practice inform one another. The findings of this study reflect this; participants' comments relate to the meanings and interpretations they attribute to alcohol use, abuse, and dependence, as well as to their experiences while nursing patients using alcohol at risk levels. These comments relate to the problem this study is designed to address: that is, the fact that health and social problems result from at-risk alcohol use may be avoided with early identification and the application of appropriate health interventions. The findings suggest that in the participants' experience, the patient using alcohol at risk levels sometimes "slips through" screening and assessment, and so remains undiagnosed and untreated, with all the potential consequences that this entails.

I found that five major themes and twelve sub-themes emerged from the interview data; these represent the participant’s experiences involved in nursing patients using alcohol at risk levels. When applicable, the naming of the themes and some of the sub-themes was taken verbatim from the interview data to add further depth, richness, and meaning to the subject matter. Each of these thematic interpretations is described and linked to examples from the data to provide the reader clear understanding and insight about the practice of the medical and surgical nurses. It is important to note that the themes and sub-themes are not mutually exclusive; rather, they are interconnected and many aspects of the thematic issues are
interwoven, thus reflecting the nature of nursing practice. The major themes and sub-themes are:

A. Establishing the Nurse-Patient Relationship – creating comfort and rapport; acquiring patient trust

B. What to Name It? – participants’ diverse theoretical understandings; underlying attitudes towards alcohol use

C. Slipping Through – communication issues; working with the CAGE Questionnaire; attempting to elicit information

D. Getting the Brunt of It – concerns for patient safety; concerns for nursing and staff safety

E. Opening the Door – nurse-initiated patient teaching; patient reluctance; locking out the elderly

Establishing the Nurse-Patient Relationship

This theme concerns the participants’ belief that it is important and necessary to establish a relationship with patients before engaging in discussions related to alcohol use. The related sub-themes concern the participants’ attempts to help patients feel comfortable and relaxed: in their words, they tried “to establish a rapport” in order to acquire the patient’s trust. The participants believed that without a good nurse-patient relationship, the patient would not be willing or be forthcoming regarding alcohol use.

The participants identified various strategies when preparing to approach patients for at-risk alcohol use. Most suggested that engaging the patient in a dialogue of some kind was helpful. They described such dialogues as “starting with a friendly conversation – you try and make it easy for them”. Patient conversations, participants noted, were made successful by “keeping the discussion as light as possible”. A number of participants referred to the need to
“establish a rapport” when they described their attempts to communicate with patients, and noted that they needed to be careful not to “put them [the patients] on the defensive”.

The main screening tool the participants used was the CAGE Questionnaire (Appendix B), which consists of four questions whose first letters are C, A, G, and E to form the eponymous acronym. Other comments alluded to the feeling among participants that, without first establishing some kind of communication channel with a patient, it could be difficult to obtain accurate information related to alcohol use; for example: “If I started with the CAGE right off the top [I] would be very surprised if anybody would answer honestly to it”. Most participants had found through experience that the CAGE Questionnaire was not useful or effective as the first approach to a patient; in fact, they reported that without the nurse’s introduction of the screening process, the CAGE Questionnaire tended to be less useful. When participants described the context of nurse-patient communications, they cited a lack of privacy as a barrier. For example, in a ward situation, a confidential conversation is awkward, as the only “privacy” it can afford is with drawn curtains. To overcome some of the difficulties for patients, participants described taking enough time, refraining from making judgments or accusations, and ensuring the patient’s comfort (and avoiding offence) by asking the patients how they would prefer the nurses to address them:

I think it [the patient being open] comes from the fact that we have time with them. It would be much better if we had a more private place; our place is not set up but we do the best we can. We pull the curtains...and then we start off with questions like “What do you like to be called?” ...at the end of it they feel we have developed a bit of a rapport with them by that time so it’s partly because its that length of time and we tell them it’s just information gathering; it’s not...we don’t accuse them in any way, it’s just information gathering before their surgery that is important to their health.

Similarly, participants described using a combination of strategies to try to break down barriers, for example:

You kind of develop some sort of rapport. Like...it’s not the first thing that needs to be asked. It can be done within the first couple of hours so like bringing them in, just being...having a good presence, being warm, caring, and
doing a good assessment, [using] attentive listening skills and develop[ing] rapport right away. And then asking those questions rather than jumping down their throat. Like, "how much alcohol have you had?"

Other participants identified additional issues that needed to be considered when patients felt ill at ease. Several participants offered suggestions such as, "a lot of it has to do with the explanation; just establishing an easy exchange"; "I guess when I sit more relaxed and also sort of bring it in not sort of as questioning but just bring it up more casually and not as say, 'Do you drink or anything like that?'"; and "talking to the patient one-on-one... and I try to give a lot of preamble, just saying like, 'some of these [CAGE questions] are very personal.'" In general, participants described trying to mitigate the unease of patients with explanations of the medical need for alcohol-related questions, and the use of a low-key, casual style of communication to prepare the patient.

The development of trust was as follows:

So we kind of establish a rapport. I think drug and alcohol is a very personal...and as I say, most people have built up defenses and you're not going to get honest answers out of somebody unless you establish a rapport with them and they realize that you're trying to get some information that's going to help them while they stay in the hospital.

Some participants suggested that a good strategy to establish trust was to try to create a safe and comfortable atmosphere for patients as a prelude to interviewing them about alcohol use:

I hope I do [create a safe atmosphere] because I find you get more honesty. I mean, everyone is defensive. We all have defense mechanisms built in, and it's natural, especially when you're dealing with an addictive personality, we tend to be very defensive... people... over years of practice.

However, it is also worth noting that the trust issue was one that went both ways: just as the participants questioned patients' accounts of the amount of alcohol they used, the participants also perceived that patients apparently did not trust their nurses, and suspected their motives in asking them questions about alcohol use. In the face of this perceived patient defensiveness, the participants explained, they felt they had to deploy various strategies to try to obtain the information about alcohol use that they needed to ensure the patient's well being would not be
compromised during hospitalization and medical or surgical treatment. The participants agreed that the need to try to establish trust with patients was a prerequisite to their attempts at discussing matters involving alcohol use. The aim, in general, was to elicit accurate responses about patients' alcohol consumption, but most participants felt that the responses they received were not accurate.

What to Name It?

This theme concerns the ambivalence and lack of consensus regarding the classification of alcohol dependence. The related sub-themes pertain to the diversity of theoretical perspectives identified in the data to describe alcohol dependence and the underlying participant attitudes enmeshed in some of the theoretical perspectives that flowed into nursing practice.

The diversity of views expressed by the participants when discussing how they classified alcohol dependence reflects a similar finding in the literature review, and reflects the ongoing debate in both the medical and public domains with respect to classification. The fact that participants in this study were not strongly convinced by the argument for a disease classification, was an interesting finding: only two claimed to favour the disease viewpoint; others expressed views that aligned primarily with the psychological and moralistic perspectives. The disease classification was the only one that participants specifically named, whether they agreed or disagreed with this perspective.

The Disease Perspective

Two participants stated that they perceived alcohol dependence as a disease. Comments regarding this issue included the opinion that this perspective is not generally accepted, either by the nurses or by patients:
...it's often not thought of as a disease usually...I think that people just think that they're weak a lot of the time or they could stop drinking if they wanted to and I...and I think...that...I mean most of the...the majority of the people who have alcohol or drug dependencies are actually functioning people in our society but I mean they may spiral down but we tend to think of the "down and outs" all the time as the ones that are the problems...

Some expressed a more equivocal view of the disease perspective, or uncertainty about classification, which the following comments illustrate:

I see it more as a disease perspective. A person has a predisposition, either through hereditary or whatever, to be more dependent on alcohol or drugs or other forms of dependency like gambling and I think it is more of a disease process rather than just... 'I'm going to drink, and that's it'.

I tend to be more along the line of 'the addictive personality'. I'm not disputing that it's a disease. I just don't see tangible proof to sustain that description or whatever the right word is. I just see it as a personality trait...maybe I just haven't read enough data on it being a disease.

...I don't know whether I consider it a disease or just a major health problem. I mean, everything can be termed a disease if you want it to be... but I'm not sure what kind of category I would put it in...

Those participants who were uncertain about the disease perspective suggested that alcohol dependence might instead be a psychological issue, or a moral one, although they did not supply a specific label for these alternative views.

The Psychological Perspective

Some of the participants made it clear that they were not in doubt, and had rejected the disease perspective. A few indicated that they instead embraced the psychological point of view (without, as I noted, actually naming it as such):

...I don't really consider it a disease. It's sort of...I don't consider it a disease...no. I would consider it more sort of you can use it as a coping skill...a coping mechanism

...I don't necessarily see it as a moral...I see it as a coping skill for a lot of people as opposed to being a moral weakness.

Participants also suggested that for patients to examine their alcohol use they would need to initiate a personal and critical self-reflection on their use of alcohol:
...a disease process that people would prefer not to have to deal with because a lot of it also has to come down to dealing with it themselves as well because a lot of people would then have to take a good look at themselves and see what their drinking patterns are like as well, and that might be a little conflict.

Such perceptions may align with the psychological perspective, or with the moralistic one, in which patients are expected to take "a good look at themselves".

The Moralistic Perspective

Although participants did not label their own perspectives as aligning with the moralistic perspective, many used social labeling that is characteristic of this point of view. These social labels included terms to describe the individual as "alcoholics", "drunks", "down-and-outs", "East Van types" and terms to describe the characteristics and features seen to be associated with the disease process itself as "stigma", "spiral down", "don't want to admit it", "vicious circle", "drinking problem" and "shame over ... alcohol use". Such terms resonate more with a moralistic perspective than any other; some acknowledged these as their own views, others described their impression of the perspectives of others; a few made it clear that they acknowledged the stigmatizing effects of labeling, with comments such as: "...you say "alcoholic" and they're going to be pictured as this person...the stigma...".

Participants used such terms as "alcoholics", "drunks" and "drinking problem" as social or diagnostic labels while describing the difficulty of determining how to assess a patient. Participants' comments included: "...it's hard to decide when people are alcoholics or not and I tend to just put, 'very heavy'...or 'heavier alcohol use in the past'"; "...you might have a drinking problem but you're not an alcoholic"; or (with respect to the way patients might view their own alcohol use) "...I think often people get the idea that they're just drunks and it's their own fault they do all this drinking, as opposed to seeing it as a disease process". The participants' comments sometimes included terms that are best described as "social labeling"; these labels were sometimes used to describe the participants' impressions of the way patients
felt about alcohol use, but also revealed something of the participant’s own attitudes. For example:

I think some of them may not want to admit it and may not want to be labeled an alcoholic, the stigma of being an alcoholic...I think you sort of have that thought of that East Van type of down and out person and don’t see themselves in that world either so they just minimalize their drinking cause you don’t think of the alcoholic as being well-dressed businessman sort of thing...necessarily...it can be quite hidden...

This sense on the part of the participants that patients were ashamed of their alcohol use was the subject of a number of comments. One said, “I feel that maybe they didn’t trust me but I feel that maybe they’re having a hard time dealing with it themselves and they don’t want to be considered an alcoholic”. Another commented, “people still have that stigma that they could do something about it so easily...they can just stop drinking and what’s their problem”. Another alluded to similarities between nurses’ reluctance to embrace the disease perspective and patients’ difficulties with believing that they have a disease, suggesting, “I don’t think they, themselves, see it as a disease as well...like they feel ashamed as well that they can’t deal with it.” Most participants were convinced that the majority of their patients who used alcohol were ashamed about it, as this comment suggests: “I think people have a lot of shame over their alcohol use...they feel bad, they drink, and then they feel bad, they drink and it’s just a vicious circle”. A number of participants agreed; some described their sense that shame over alcohol use is sometimes apparent among those who use alcohol at risk levels:

...there’s a lot of shame in doing anything to excess, especially when it impacts your life...a young mother having to have alcohol in front of her child, an older woman ashamed that they have their drinks and they’re justifying which makes me think that it must be shame because they wouldn’t just feel they have to justify why they have what they have...

Participants’ Underlying Attitudes Towards Alcohol Use

A few of the participants’ comments referred directly to personal attitudes towards alcohol dependence brought to their nursing practice, and also to the effects their nursing
experience had had on their evolving understanding of alcohol use. They also shared personal stories to illustrate their perceptions of the attitudes of some nurses.

Some of the participants described themselves as being judgmental or susceptible to anger at the beginning of their nursing careers, but with time and experience found that they developed more understanding and tolerance. Comments regarding this included the following:

...when I first did see people who did drink, at first it was judgmental but since that [then] I have changed my opinion as I got more and more understanding along the way and I think the young ones [the nurses] coming in, too, until they have more experience too, I think some of them might still be judgmental...

...I think in the early years before I really had a lot of dealings with it, I was afraid of it and maybe I was afraid of seeing me having a problem with it and then I was angry 'cause I feel I should have more control...

The following comment expressed the attitude some of the participants felt was appropriate when nursing patients who use alcohol:

...try and treat people how you want to be treated...and I don't feel we have the right to judge...you have got to find out the reasons behind a lot of things...how they cope...and I don't think one has the right to judge that...

Finally, some personal anecdotes illustrated the experience participants had with the attitudes of nursing colleagues. An example offered was a nurse's husband who had experienced the judgmental attitudes of nurses first hand: although he had stopped his alcohol use several years previously, he felt that the nursing staff expressed judgment in the tone of their voices when asking him if he was an “alcoholic”.

In general, participants' comments alluded to their struggles as they tried to come to terms with classifications of alcohol use, current and traditional terminology, the impact of social labeling, their personal beliefs, and the beliefs of their patients.

Slipping Through: When Screening and Assessment is Compromised

When a patient experienced an unanticipated acute alcohol withdrawal, the participants identified the patient as “slipping through” the screening and assessment process. Associated
with this theme are the following sub-themes: communication issues with the medical staff, co-
workers, and patients; working with the CAGE Questionnaire; and attempting to elicit
information. Although systems issues (e.g. emergency surgery) can result in an undetected
alcohol withdrawal, this discussion focuses upon the participants’ experiences in screening and
assessment process for at-risk alcohol use.

The study participants believed it was important to screen and assess medical and
surgical patients for risk of potential alcohol withdrawal, and also to ensure good
communication practices among staff members so that they do not miss any information
important to the patient’s well-being. The participants described several barriers that impeded
their ability to obtain necessary information about patients’ use of alcohol. One of these
perceived barriers were ineffective lines of communication with other staff members – primarily
the medical staff, but nursing colleagues as well. A further barrier was patient defensiveness
and reluctance to disclose. Finally, the participants commented that assessment tools could
themselves constitute, or contribute to, barriers.

Communications with Medical Staff

The study participants expressed frustration with medical staff with respect to patient
assessments for at-risk alcohol use. When physicians were inattentive, or unwilling to consider
the nurses’ professional opinion that a patient was at risk for alcohol withdrawal, the nurses’
jobs became more difficult. Even when a patient exhibited alcohol withdrawal symptoms, some
nurses commented that they sometimes found it difficult to gain the attention of medical staff
and obtain the necessary support. Participants offered descriptions of interactions with medical
staff members who had not attended to assessments that nurses had made; for example:

...being firm and not putting up with crap...saying what you need to say and if
they start brushing you off, 'No, I need to tell you this.' You just don't go and
say, 'She's got night sweats.' You kind of prove your case really well.
They also described the necessary persistence of nurses in such a situation:

...we just advocate for them [the clients] and do the best we can and if the doctor doesn’t... we try, if we can...we ask another doctor or maybe get one of the more senior nurses to talk to the doctor

Most were frustrated when they encountered a medical staff member that failed to communicate or to provide appropriate support; the participants noted that patient care could suffer as a result:

And it's a major issue, healthwise for them and for us. But I don't know how we're going to change it. If doctors and surgeons [and things] don't communicate with each other then it is a problem that's just going to carry on the way it is. And then we're just going to have to wake somebody up in the middle of the night and say, ‘So and so’s going through the DTs – can we have an ativan or valium order?’ and sedate them and then we get into surgical problems after that because we sedate them too much and the surgeons get angry at us for sedating them but then what are you going to do because they can hurt themselves if they carry on.

As participants pointed out, there is an element of risk for the nurse as well when she must take an action to ensure patient safety in the short term (e.g., sedation) that causes difficulty in the longer term (e.g., post-operative complications).

Another frustration participants mentioned was the frequent failure (they perceived) of medical staff to assess the patient and advise the nursing staff, for example when a patient is at risk for alcohol withdrawal:

...if they’d given us a heads-up when the patient was admitted and started stuff, you know, but they don’t do that...and they’re always so surprised...a lot of the surgeons and staff are so surprised. Like ‘Oh, really? He drinks that much?’

Participants related other similar experiences that they described as a source of frustration and unnecessary difficulty. One such story described an MD who had refused to provide sedation orders for a patient in delirium tremens despite the fact that the patient had threatened to kill a nurse. The patient subsequently needed to be placed in physical restraints, and as a result of the physician's failure to provide support, the nurse's entire shift was "disrupted" and she was unable “to focus on other patients” for the rest of the night.
I was not happy with the response about that problem...I thought, "If you want to make that decision, you should be here and assess that patient...give us a hand to assess him". But it wasn’t fair.

Part of the frustration participants felt in such situations (when physicians were not supportive of nursing practice and needs) stemmed from the fact that nurses must rely on physicians to ordered medication, and when they failed to order appropriate medication, it tended to be the nurses who had to deal with the negative consequences hours later.

Communications with Nursing Colleagues

Participants’ comments suggested that nursing as well as medical staff sometimes failed to obtain and communicate important information about patients. The participants noted that they were sometimes frustrated with their nursing colleagues when they were not consistent in screening and assessing for at-risk alcohol use. Example of this included the following:

...there’s something about asking somebody a personal question that they [nurse colleagues] just want to avoid it, whether or not...I don’t know if they get embarrassed...they’re not looking at it, as this is an issue that relates to this man or woman’s life. And maybe it’s the way they are the questions [CAGE] are worded...I don’t know, I’m not that much of an expert but I’m just saying it’s...they don’t get answered and I know that’s the reason. They don’t get asked I should say and that’s the reason.

A further frustration towards nurse colleagues occurred when they fail to administer sufficient amounts of sedation to manage a patient experiencing an acute alcohol withdrawal.

...less experienced staff afraid to give the meds...you don’t want to give too much or how do they give [parentally or orally]and ...oh he is calm now, I won’t give him anything...and you come on nights and they’re climbing the walls...relates to pain medication [expertise]...

Participants comments about nursing colleagues related to their concerns that problems could arise when they lack the necessary confidence or expertise to handle pain control in the medical or surgical patient who is using alcohol at risk levels; or, problems could occur because of some nurses’ beliefs about pain medication and pain control:

I’ve seen nurses who are afraid of high dosages of pain medication and not realizing that some patients need high doses and if you don’t keep on a regular
basis, the pain gets so out-of-control that what you are giving isn’t going to help whereas you keep them on a regular basis of pain medication then things run smoothly...

Some nurses, participants suggested, are not aware that careful monitoring and preventative measures can keep the patient (and the nursing staff) safer, as these participants pointed out:

Don’t let them get to the point where they’re ripping out their IV. If you see them trying to get out of bed, that’s the time you give them something.

...get the meds, start right away maybe he won’t have the DT’s [delirium tremens].

The participants expressed frustration with the additional challenges that arose when a routine postoperative course is complicated by unforeseen withdrawal symptoms due to inadequate screening, assessment, or communications between staff members. Examples of such comments included: “they’re post-op and you’re suddenly not looking after their surgery so much but looking after this withdrawal.” Participants noted that their frustrations related to the fact that the risk to patients was higher, and the nursing task was more complex, when alcohol dependence remained undetected and withdrawal symptoms occurred.

Communications with Patients

Participants had significant challenges in obtaining information from their patients. A majority of participants held the view that it was uncommon for patients to be accurate regarding their disclosures about alcohol use. Participants perceived that barriers to their successfully obtaining information from patients were patient defensiveness, difficulties with the screening tool, patients’ ignorance of the seriousness of the risks of alcohol withdrawal compromising their health care while in hospital, and patients’ resistance to nurse teaching.

Some of the opinions that the participants expressed with respect to nurse-patient interactions were that many patients felt shame or guilt about their alcohol use, or that they felt judged and therefore became defensive or angry when nurses questioned them:
...they [the patients] think you're judging them sometimes. And you have to sort of explain to them it's not really judging them: it makes it easier for us to treat them...but a lot of times you do get a little bit of anger there because they feel it's a judgment on them.

The participants suggested that patients experienced “guilt” and “shame” regarding their alcohol use, and that they thought the patients’ guilt feelings were instrumental in creating barriers to accurate disclosure, or compelled patients to try to justify their actions (i.e., drinking). Comments with respect to this belief about patient guilt included: “I think the more guilt there is the more chance they're going to lie about it [alcohol use]”. Participants noted strategies they had found effective when confronted with such actions including expressing empathy (with the patient's need to justify and sense of being judged) or even by referring to a personal challenge:

I guess I hear a lot of justifying which makes me think that it must be shame because they wouldn't just feel they have to justify why they have what they have and I try and tell people you don't have to justify, this [referring to the CAGE] is just an “yes or no” answer and...I often...I think I often say to somebody, you don't need to be ashamed...the same as I don't about my weight. I mean that's an issue and I think that it puts people at ease because they realize I'm not perfect either...I am sitting there as a human being that has my own issues...

One of the participants speculated about a possible mechanism at work in these negative, or unsuccessful, interactions between patients and nurses, suggesting, “there are a lot of people that drink[who] probably have a guilty feeling. A lot of them deep down feel guilty, so us asking the questions brings out the guilt.” However, the participants felt that in addition to the shame and defensiveness they perceived in their patients, other factors were at issue in the screening and assessment process. Some said that the assessment tool itself, or the way the tool was deployed, could provoke a hostile or negative reaction on the part of the patient.
Working with the CAGE Questionnaire

All participants in this study used the CAGE Questionnaire (Appendix B), to identify individuals who were dependent on alcohol. A majority of participants noted that they found the CAGE Questionnaire useful, for the most part, but also found it a challenge to use for two main reasons. First, they suggested that the reactions of patients to the content of the CAGE questions were hostile or negative; and second, the phrasing of the CAGE questions did not seem natural, comfortable, or appropriate to the communication styles of the participants.

One of the participants described a patient's hostile reaction to the nurse's use of the CAGE questions, reporting that the patient responded, "my alcohol use is none of your business". The participant described the following impression of what a patient may be thinking during the screening process:

...you can tell they're thinking, "Why is that any of your business? I'm here...I broke my leg. You don't need to ask me about my alcohol".

Participants noted that they found the CAGE questions to be overly direct; they described them as "blunt" and "very in-your-face". They suggested that hostile or defensive responses to the CAGE were therefore somewhat understandable. They described the way they would try to explain the process to the patient to mitigate patients' distress, saying for example, "...this [CAGE Questionnaire] is in no way judgmental of you, I'm doing this tool to assist us, as nurses and doctors, in allowing you to get through your hospitalization without the use of alcohol...".

There were a number of comments that suggested participants felt that the content of the CAGE Questionnaire needed revision, but some participants suggested that the presentation of the content was more of an issue for them that the content itself. For example:

...the questions are pretty good...I think the only thing is the questions are hard to ask. The way they are worded. It's just...they're very awkward questions to ask. The wording and how they...they're very blunt...

Other participants had similar experiences with the tool, suggesting "rewording the CAGE Questionnaire so that people would answer truthfully." Or noting:
They’re [CAGE questions] are worded in such a funny manner [so] that if I don’t read it, it’s that I’m stumbling on my words, then I get frustrated because I think, “Oh, they’re [the patients] going to think I’m being judgmental or something”.

This comment seems to encapsulate the difficulties participants described with the tool: they felt that patients react poorly to it, nurses find it difficult to use successfully, and – perhaps most problematic – patient responses to the CAGE Questionnaire are unsatisfactory. Several questioned the effectiveness of the tool, given nurses’ typical experience that patients are not “truthful” and “honest” in response to the CAGE questions about their alcohol use. An example of such comments was as follows:

...I can’t see that it [the CAGE Questionnaire] does a heck of a lot of good because I find the people who sort of tell the truth are the people who really don’t have a major problem or people who have quit for so many years...they will be honest with us but I don’t find people who are currently drinking, really tell us the truth.

Some pointed out that the CAGE score could be very misleading, and related several experiences to illustrate this. For instance, participants noted that in their experience patients could score a zero on the CAGE Questionnaire (which is to be interpreted as indicating no potential for an alcohol withdrawal that would compromise care) and later experience a significant alcohol withdrawal. Experiences of this sort caused some of the participants “to learn to ask better questions”. Other comments about CAGE scoring included, “...I don’t like the CAGE score because you can have somebody who partakes in lots of drinking of alcohol and lots of drugging and they can still [...] answer the questions and they can have a zero score.”

Study participants also questioned the effectiveness of the CAGE Questionnaire when patients were either unable or unwilling to accept the fact that their alcohol use could adversely affect their medical or surgical condition. Many patients would not engage in a discussion regarding their alcohol use with participants, believing, the participants felt, that alcohol either was not a problem substance, or that their use of it was irrelevant to the issue that brought them
to hospital, or both. Participants made comments such as, "...a lot of people don't feel that alcohol kind of rates up there with drugs and hard-core stuff...you know they don't see it as a problem." Thus, part of the issue when nurses try to obtain information from patients, according to participants, is that they may be unaware of the medical need to disclose their alcohol use accurately, for their own safety and health.

**Attempting to Elicit Information**

It is important, participants noted, that patients understand why nurses are asking them questions about issues they may otherwise feel are personal, and not relevant to their hospital care. They usually presented the issue of screening and assessment for alcohol use to patients as a matter of ensuring their comfort, for example:

> ...we ask you this because of pain medication and because if you do use alcohol at home that there may be possibilities that you may go through withdrawals and we want to make sure that that doesn't happen.

A similar approach to help patients understand the medical issues, was one in which participants also tried to reassure patients that the nurses were not asking questions in order to pass judgment:

> And I think sometimes if there's a lot of hesitancy to answer these questions I think sometimes what we say is "You know, I'm not going to judge you [about] how much you're having or not having but some of these questions are important for the kind of medication that you're going to be getting afterwards and with your anesthetic and or just for your safety while you're having your surgery and to help with your pain control afterwards".

Participants typically reassured patients both that they were not going to make moral judgments, and that the patient would be more comfortable if their alcohol use levels warranted medication adjustments:

> I'm asking you these questions because we have a reason for it...it's not because we want to make you out to be an addict or alcoholic...this is part of a necessary nursing plan...if you take something on a regular basis, we can stop you from going through any sort of shaking, mood swings...
Another barrier that participants felt was particularly difficult to overcome was the problem of gauging the accuracy of the patients' responses to questions concerning amounts of alcohol consumed. Participants offered a number of comments regarding this perceived barrier, such as: “unless the patient tells you, we are at the mercy of what comes...we really have to get it from the patient...”. Other participants remarked that patients withhold information, perhaps because they do not believe their alcohol use will result in any problems. They explained that nurses have to depend on the willingness of patients to disclose, since the care they get is only “as good as the answers you get from people” and depends on whether “they want to give that information out”.

Sometimes – albeit rarely, according to participants – a patient was prepared to be completely honest about substance and alcohol use:

...he admitted to 8 drinks per day and smoked 3 joints a day and had no intention of changing it, didn’t feel guilty, didn’t feel in any way that he was doing anything wrong, but he wanted to be particularly honest...he just knew he didn’t want to suffer.

Most commonly, however, the participants had a difficult time convincing patients that “this information is going to help them out in hospital”.

The participants noted that they frequently questioned patients’ accounts of the amount of alcohol used, when they did disclose. A common issue that arose during the interviews was that the participants questioned the patient’s accuracy about the amount of alcohol they typically consumed.

Most of the participants assumed their patients were under-reporting their alcohol use. These examples of participants’ comments illustrate the perception of the majority that patients report only half or less of the amount of alcohol consumed:

...the age-old story is, if they tell you they have [had] two drinks, they have had four...
...but I don’t find that anyone is actually...very few patients are actually very accurate. If they say two or three, we usually think four, or five, or six, or seven, something like that...

...their two drinks are probably double that or are big drinks sort of thing...they never get specific and say, “Oh, I have two huge highballs”, or whatever, before dinner...

...if they tell me they drink two drinks and they’re a half glass with no ice or mix, then I assume, right or wrong, I assume that I could probably double that amount...

...well, you never know what people really mean when they say that they drink, you know. You often assume whatever they say they’re drinking is maybe twice that...

This lack of certainty in the accuracy of patients’ information, and the tendency of participants to automatically double the reported alcohol consumption was consistent in the data; a majority of the participants, considered patients’ failing to disclose accurately a barrier to their attempts to obtain accurate information. This perception on the part of nurses may have been one they acquired from any one of a number of nursing textbooks that state that patients consistently under-report their alcohol intake (Wallace, 1990).

Although participants’ comments tended to focus on the issue of the lack of accurate patient disclosure, the issue of obtaining information from patients is clearly a complex one. Participants emphasized the seriousness of this difficulty in obtaining accurate and reliable information, and described in detail the range of difficulties – and even dangers, as described in the next section – that arise while nursing patients whose alcohol dependence has gone undetected.

Getting the Brunt of It: The Consequences of Undetected Alcohol Withdrawal

“Getting the Brunt of It” names the participants’ experience when an alcohol withdrawal escalates to the point that the patient exhibits behavior that is out-of-control. The sub-themes pertain to safety for the patient and to the participants’ concerns for the safety of
nurses and staff. The participants encountered circumstances that resulted in their feeling frustrated and concerned for safety while they were nursing patients. As I noted in the foregoing sections, most of these frustrations arose with respect to their professional relationships and communications with the patient's ordering physician and with their nursing colleagues, but also with the patient who often fails to disclose important information. The reason participants felt strongly about these issues, they noted, was that they as nurses are on the "front line" and as such have the bulk of the responsibility of dealing with patients in withdrawal. They had substantial concerns regarding safety for their patients – as well as for themselves when they had to nurse a patient whose behavior was out-of-control.

Concerns for Patient Safety

The participants shared several vivid examples of experiences they had had with patients with an undetected acute alcohol withdrawal progressing to delirium tremens. In such cases, patients are in acute danger of injury. Participants described the difficulties they had in striving to protect the patient from self-harm:

Mostly, it's protecting the patient. Because, from experience, ...seeing how devastating [it is when a] patient is going through withdrawal, it's awful for the patient, the family and also the staff because you cannot do the kind of care you're suppose to be doing and it's very frightening for everybody around and mostly for the patient; [it's necessary] to protect them, in the long run. Unfortunately, I think lots of people don't realize that it... if you can prevent them from going through the withdrawal and the DT's it's much better than trying to solve the problem they have withdrawing.

The patient's behaviour can compromizes his or her care; for example, patients may pull out IVs or resist treatment:

...I don't think anybody picked up on the fact that he was a drinker...a few days down the road, like he had an epidural and all of this stuff and all kinds of bells and whistles post-op and a few days after we had him back he started misbehaving and pulling things out and picking at stuff and just off the top of my head said, "I wonder how much he drinks?" because he was acting specifically like they do behave...he'd fight us while we were trying to get the IV started...so it was very difficult.
The following comment also illustrates nurses’ concerns when a patient is so out-of-control that the nurses have to call security, as security personnel can be extremely rough with a violent patient:

Like with a head injury or someone who’s in alcoholic withdrawal can be very aggressive so it’s your safety, their safety and everyone else, but I find it very hard, especially if you have to get security for sometimes they just bounce on them...you try and talk them down but sometimes you just can’t talk to them.

The participants therefore stressed the importance of ensuring patient safety as a major concern, but also expressed their frustration in having to manage an acute alcohol withdrawal that could have been avoided with successful screening and assessment.

Concerns for Nurse and Staff Safety

The magnitude of violence that participants described made it clear that aside from it being an everyday frustration with which nurses must cope, they considered undetected alcohol dependence to be a serious issue that carries extreme risks not just for patients, but that also unnecessarily endangers nurses, other staff, and visitors. The nurses offered vivid descriptions of circumstances in which they feared for their own safety as well as that of patients, other staff, and visitors:

...I don’t want to get clobbered, those people can be very strong, they don’t know what they are doing, they don’t mean to hurt...whoever’s in their way going to feel their wrath so it a real safety issue...for everybody...nurses, patients, and everyone...

The experience of nursing a patient whose acute alcohol withdrawal has progressed to delirium tremens can be extremely difficult, as participants noted; the nurses provided some dramatic examples of sudden and violent incidents caused by patients in withdrawal. For example, the following description of a dramatic, middle-of-the-night “Code White” [the hospital emergency response program] illustrates the extreme danger to nurses when patient alcohol dependence goes undetected:
...he woke up at 3:00 in the morning and we heard a noise in the room and the
one nurse went in and he was standing on the bed with the chair in his hand and
he proceeded to crash the window and then, at that stage, I ran up there to see
what was happening, so ran back, call security for backup and then...by then he
took the other spare bed in the room and he jammed it against the door so we
couldn’t get into the room and we called security, Code White...we had to call
Code White, and pushed the door open, tried to get him through and so he still
had the chair in his hand and he went and crashed the other window. There was
glass everywhere, he was barefoot, walking around and then he came back with
two feet of glass, holding it in his bare hands and he was...want to know who
was in charge and [the nurse said] ‘she is’ and he said, ‘Okay, I’ll cut your throat
first and then I’ll finish the others. You want to come in here?’ And he was
walking around holding this glass and blood streaming down; anyway security
came stat and they were able to get the glass off him...

This example underlines the seriousness of alcohol withdrawal symptoms, and risks associated
with the consequences of undetected and therefore unmanaged withdrawal. Nurses’
descriptions of patients experiencing acute alcohol withdrawal indicated that they have
significant concerns – even fears – about injury and abuse from out-of-control patients in
withdrawal. The following examples of participants’ comments are typical of the experience of
nursing patients in acute alcohol withdrawal that progressed to delirium tremens:

And they say dreadful things to you and they do dreadful things and they’re
strong and they’re vicious...

[delirium tremens] certainly can be frightening. Sometimes your physical safety
and it can be a lot of worry for the patient...and some people really go through
the DT’s...it’s very frightening for the patient and their family...they’re all over
the place...then they go completely wacky...they’re trying to get out of bed...it
can be a lot of worry for other patient safety...

...there’s been a lot of thrashing and a lot of hitting and a lot of Code Whites

Could be a danger to themselves. And also a danger to me! [nurse] I mean I’ve
had a little old lady that just lopped off and threw a leather restraint right at my
head and one of her surgeons came into the room and she bit him. I told him not
to go near her!

...I don’t want to get clobbered. Those people [experiencing delirium tremens]
can be very...they don’t know what they’re doing...and they don’t mean to hurt
you but they just want to get out of there and they’re going to get out no matter
what and whoever’s in their way is going to feel their wrath so it’s a real safety
issue...for everybody...for everybody concerned; nurses, patients, everyone.

And, you know, like I said, often safety is a big issue because they’re usually
bigger than us and stronger than us, and they’re amazingly strong. If they get a
hold of you, the potential for them to hurt is big and I guess that’s what makes me; that’s the part I hate, like you know, just say to...like if there’s other patients in the room, we’ve often said like we don’t get paid enough to deal with this kind of thing; with them trying to slug us while we’re trying to keep them from hurting themselves and that sort of thing. And that’s what usually comes up; it’s all the...you know...and then we have to hurt...sometimes hurt them, you know, restraining them and that sort of thing but it’s sort of their safety...our safety sort of a big issue because of their behavior.

Like they grab your arm or something and squeeze or twist it or do whatever. We did have one girl get hit across the head with a cane...picked up his cane and whacked her one so she was off for awhile and another family member was drunk, assaulted another girl.

These stories illustrate the level of aggression that is typical of a patient with delirium tremens, and underline the seriousness of the challenges nurses face.

When expressing the frustrations experienced when patients who used alcohol at risk levels went undetected, participants’ comments seemed to sum up the feelings of many nurses on this subject: nurses feel they are “get the brunt of it”; it is often nurses who suffer the consequences when such patients become violent and abusive.

Opening the Door to Patient Teaching

This theme relates to patient teaching about alcohol use. The participants described a range of problems with presenting educational opportunities to patients using alcohol at risk levels. These included the patient being too ill or overwhelmed with information regarding their immediate hospitalization experience. The sub-themes identified relate to: limited patient teaching regarding alcohol use; participants needing to have the patient “open the door” prior to initiating any patient education about alcohol use; and “locking out the elderly”, relating to the finding that the participants did not engage in patient teaching about alcohol use with elderly patients.

Participants responded to nursing patients through an undetected alcohol withdrawal, (despite their frustrations with the necessary changes to the nursing plan) as a matter of course;
however, only some of the participants described regularly engaging in patient education regarding the health impact of at-risk alcohol use. Thus, although several participants noted that they felt patient teaching was a priority, others questioned whether the hospitalization period was an appropriate time for discussions about alcohol use. Some participants also believed that certain patient populations – in particular the elderly – were unlikely to maintain abstinence and did not see patient teaching as a worthwhile endeavor.

Nurse-Initiated Patient Teaching: Opportunities and Barriers

Several participants suggested they preferred not to address the subject of alcohol education with patients who were too ill and already inundated with information regarding their present hospitalization. Participants expanded upon this, commenting, “we’re getting ready for surgery and you don’t want to add ...any more. That would be a huge life decision if you’ve got to confront that you have an alcohol problem” and, “...they’re too ill with us...they’ve got too much going on to recuperate from their surgery...I’ve never found them sort of willing and able to kind of deal with alcohol issues at the same time...”. Other comments, in a similar vein, included the following:

...they might be just too stressed out about...like I said, you know, we’re dealing with surgical patients and we’re usually, 90% of the time, dealing with somebody who may be facing cancer and stuff like that so I’m not sure it’s sort of an appropriate time for them to sort of have anything else thrown at them because they’re...once they come to us, they’re going through a lot of information...

...most of the surgery that we do is pretty big stuff...bowel surgery, cancer surgery, that sort of thing and big enough issues to deal with, getting over that than deal with anything else...

Although some participants referred to the receptivity of patients to educational support, it was not always the case that the nurses’ did not engage in discussions related to alcohol use because of their patients’ preferences or their perceptions of those preferences. Some described their choice not to offer teaching; such comments included: “I can’t remember ever asking
anybody whether they would like any help in that direction”. Some participants were unclear about the role of the nurse in providing educational support; comments to this effect included: “Well, I would suggest that maybe they go get into contact with AA or something to that effect as I don’t feel that I can personally help them.” Some participants felt that it was not the nurse’s role to discuss alcohol use and provide teaching on the issue; others may have been willing to do so but expressed a sense that they didn’t feel “trained to help”.

Other participants suggested nurses did not know enough about the health impacts of at-risk alcohol use to consider initiating a discussion related to alcohol use; some suggested fellow nurses might not address alcohol-related problems as it could potentially bring up personal issues regarding alcohol consumption.

Some of the participants, when discussing treatment for at-risk alcohol use, suggested they would “ask them if they’ve ever looked into alcohol or drug programs or something like that. But it is not something...it’s not something...it’s not something I actually do.”

Some of the participants found it effective to teach about the effects of alcohol use by working with families, noting for example, “I’m not sure we’re going to fix them ...what’s actually is going on ...and explaining to them that this is a result of his alcohol consumption... it is often a very big eye opener.” Other participants expressed opinions on the nursing approach to patient education, including the following:

...we’re kind of flying by our pants in that way [patient teaching]...I guess people are more concerned at that point about getting their meals, getting their medical equipment in, make sure that somebody comes and takes care of their medical needs. This is a huge issue...alcohol/drug abuse. No...I don’t think that we are doing a good enough job.

A few participants suggested that not only were they not prepared to address alcohol use education, but they were also in favour of allowing some patients access to alcohol. Comments to this effect included:
I'm not sure I would address the issue of them say quitting or getting some kind of help for the whole thing. What I think would be beneficial to some of our surgical patients...let them have their alcohol...

Some participants also expressed the belief that it was not useful or effective to exert an effort to try to convince some patients to modify their alcohol use patterns.

Nurses' Perceptions of Patient Reluctance to Patient Teaching

In determining whether a patient was receptive to information regarding alcohol use, participants noted that they tended to judge this by gauging the patient's response to the CAGE Questionnaire. If they experienced a negative response, they did not pursue the topic. Other participants' comments reflected similar approaches, that is, assessing a patients' willingness to engage in discussions related to alcohol use before broaching the subject:

I learned to back off a lot and now I put out feelers...and if they look positive about it and give me a positive reaction to it, I'll say, "Well, we do have information; its at your discretion whether or not you want...do anything with it."

A number of participants noted that they needed an indication from their patients that they were open to educational opportunities:

I would feel that I would need something from them. If they gave me some kind of insight as to a reason that the teaching was needed, I would totally give it but I don't think I would be the one to step in and give it without them giving me that forward to go ahead. To me it would be a bit too invasive...they have to be able to want to quit themselves or want to cut down...me nagging them saying...Well this is what it's doing...look at the nurses that smoke...they know exactly what it does and they don't care so I would need some kind of insight there to continue that kind of teaching...

A number of participants suggested that to discuss alcohol education with patients would be "nagging" them; some also alluded to the treatment focus of the moralistic perspective on alcohol use – that is, that a patient could stop drinking if he "wanted to":

I think because people have to want to stop or decrease their alcohol usage...me nagging them for seven days, seven months, or seven years straight isn't going to do anything. They have to want to be able to do it themselves.
Other similar comments illustrated doubt on the part of some participants in the willingness of their alcohol-dependent patients to consider a behavioural change; as a result of this perception, some did not feel that offering educational options to their patients was likely to produce the desired result:

...if they didn’t give me a little ounce of why they should...or that they feel like they should cut down or stop, I don’t know if I would (offer education)...

...if they show an inkling of sincerity towards being wanting to be helped or find out the information, then I am very forthcoming with it but... it’s a very...discouraging area...

Similar comments also aligned with a moralistic perspective on alcohol treatment included: “I would think that if you’re serious about dealing with your alcohol problem you should look it up in the place [for treatment]”.

Others, though, suggested that negative experiences in the hospital, such as problems related to withdrawal, might precipitate a desire for change:

...it’s through them (patient’s family) that we can often sort of do something because they see what’s happening and it’s a good eye opener for them to realize that what’s going on is related to alcohol...”Oh Dad you did this” or “Mom, you did that and you were pretty nasty”.

Overall, the tendency among participants was to expect that the onus should be on the patient to indicate receptiveness regarding alcohol education or treatment; some participants chose to offer education or referrals; other chose not to make the offer.

**Locking Out the Elderly**

One patient population in particular with whom the participants did not tend to address alcohol use issues, was the elderly. Participants identified the elderly patient population as a special case with respect to managing alcohol withdrawal, and some suggested that a possible solution was that this group be given alcohol to better manage their hospitalization period.

Comments describing the participants’ different perceptions of at-risk alcohol use in the elderly included:
They’re [elderly] tired and they don’t have a lot of strength and they...a lot of them can’t overcome alcoholism. For them to stop they have to have the will to do it and a lot of them don’t. You give them the options and you try to help them but just looking at their frail little faces and just...have a drink, honey, just go ahead, like if that’s...once you’ve lived to 70, 80, 90, do what you want. Have an ice cream every day, have a drink...as long as you realize all the consequences and you’re okay with what you’re doing.

Some participants felt that the elderly no longer had the mental capacity to address the question:

I think when they [elderly person using alcohol] started they knew, maybe with so much abuse their mental capabilities may not be there any more but I think they do but they just don’t want to admit it.

In general, there was a marked difference in the participants’ approach to alcohol use by the elderly compared to the approach they took to younger patients. Participants tended to be more tolerant of alcohol use in the elderly, and to avoid offering interventions. Some suggested that alcohol use in the elderly might not be harmful enough to their health to merit intervention (because, some noted, the patient had lived a long life already); others felt that the elderly were unlikely because of their age to be able to change their behaviour. Most considered that offering alcohol was a viable solution to the potential problem of alcohol withdrawal for elderly patients.

For example:

Well...I feel if...like I’m not sure we’re going to change them [elderly]...if they’re elderly people I don’t think we’re going to be able to sort of fix a lot of the, you know...sort of thing. I just feel...and like in a lot of nursing homes and stuff they do give them their alcohol. Let them have some and I...to me you might as well carry it on. I don’t see trying to stop them and make them quit doing it and stuff, you know, if they’re in their 70,s and 80's sort of thing.

Participants who avoided teaching the elderly about alcohol abuse offered explanations such as the following anecdote about the different consideration some felt the elderly required:

...because they’ve already had a whole history of it. It’s like my grandfather who use to put tons of salt on his food. He was 95 years old and my mother said, ‘Don’t use so much salt!’ And I said ‘Mom, he’s been doing it for 95 years, we’re not going to change him.’ So an elderly person has already established that...he’s 80 years old! Why do we want to change him now? The younger ones, maybe we’d like to see them get help. I think the more than helping the younger ones not get into this habit or reduce...I mean an 80 year old has already been
okay and he hasn’t run into any difficulties and he’s okay. The young one could develop more serious problems.

This last comment suggests that participants may have had a more tolerant attitude toward the elderly than their other patients, but also that there may be a tendency to “give up on them” because of their advanced age, reduced capacity, and frailty.

Summary

The interviews produced a rich set of data that provides the opportunity for insight into the meanings and interpretations nurses attribute to alcohol abuse and dependence. Seen from the perspective of those who provide nursing care to patients who use alcohol at risk levels, it is clear that there are many challenges related to alcohol abuse and alcohol dependence that impact this area of nursing practice.

The study participants offered both direct and indirect evidence of the theoretical perspectives they have adopted and brought to their practice, primarily the disease, psychological and moral perspectives. Some of the participants offered some personal views on their own perspectives and those of nursing colleagues. They also described the specifics of their attempts to obtain information about patients’ alcohol use and the challenges they encountered in their attempts to do so. Additional valuable information emerged with respect to specific concerns related to the nursing of patients who use alcohol at risk levels; these concerns included the challenges of discussing alcohol use with patients, and the consequences for patients and nurses when screening and assessment did not detect alcohol dependence, and withdrawal symptoms occurred.
CHAPTER FIVE: DISCUSSION OF THE FINDINGS

In this chapter, I discuss the findings of the study. To further enhance the analytical and interpretative processes, I have examined the themes and sub-themes in conjunction with current understandings in the literature relevant to the subject of nursing patients with high-risk alcohol use. This discussion will enhance our understanding of the meanings and interpretations attributed to alcohol abuse and alcohol dependence by medical and surgical nurses. The intention of this analysis was to facilitate comprehension of the data by synthesizing the meanings of the themes and sub-themes, uncovering the relationships among the themes, and recontextualizing the data into findings (Morse, 1991).

The Structure of the Discussion: Thematic Sections in the Nurse-Patient “Story”

The aim of the discussion is to contribute to a greater understanding of the meanings and interpretations that nurses assign to high-risk alcohol use, and to develop greater insight into the effects of these on nursing practice. I have organized the material for this discussion in consideration of the themes and sub-themes that emerged through my applications of the interpretive descriptive analytic method.

This discussion is presented as sequential thematic sections to represent the chronology of the typical admission “story” of the nurse-patient interaction during a hospitalization experience. Each section of the hospitalization experience story contains the relevant themes and sub-themes as identified in chapter four. The themes and sub-themes are not necessarily specific to a particular section; rather, the concepts, issues, and processes they represent may be understood to permeate and flow between the sections dynamically, reflecting the dynamic nature of nurse-patient relationship. This flow between sections is particularly apparent with the sub-themes concerning comfort, rapport, and establishing patient trust.
This approach to conceptualizing the data is in keeping with the suggestions of scholars such as Sandelowski (1991) and Thorne et al. (2004), who suggest that such ordering of the analytic material as a story can help the researcher to perceive meaning, patterns, and themes in the data and to provoke new understandings of the subject under investigation.

The first thematic section in the story begins when the patient using alcohol at-risk levels enters the hospital and meets the nurse and the nurse-patient relationship begins. This section is entitled Beginning the Nurse-Patient Relationship; the sub-themes relate to the nurse’s attempts to create comfort and rapport to acquire the patient’s trust: specifically, these sub-themes are discussed in this section under the headings “the therapeutic relationship”, “the unilateral relationship”, and “the problem of therapeutic relationships with alcohol-dependent patients”. Various factors may affect the ability of the nurse to establish a rapport with the patient. These may include the patient’s health status, beliefs, and experiences of being an at-risk alcohol user, the nurse’s personality, the nurse’s history of nursing alcohol dependent patients, and the nurse’s and patient’s interpersonal skills. Each of these factors affects the way the story of the nurse-patient relationship will unfold.

The next section, Screening and Assessment for At-Risk Alcohol Use, relates to the nurse’s screening and assessment of the patient for various conditions including at-risk alcohol use that may affect the planning and outcomes of nursing care. As the nurse is concerned with screening and assessment processes, the sub-themes that arise pertain to communication issues and screening processes and tools. In this section, these issues are discussed under the headings, “working with the CAGE Questionnaire”, “incentives to disclose during assessment”, and “nursing education for screening”. The validity of the information the nurse is able to obtain depends to an extent on the assurance that there is trust in the nurse-patient relationship. When patients using alcohol at risk levels are not identified as such, there are
adverse effects both on the practice environment and on patient outcomes: the theme related to this is “slipping through”.

In the section entitled Negotiating the Nurse-Patient Relationship, I discuss processes through which the nurse and the patient negotiate an ongoing relationship, the success of which depends on personal and interpersonal factors that are affected by the ongoing influences of the practice environment. In this section I discuss the ways that both the nurse’s and the patient’s underlying beliefs with respect to alcohol use, and the interpersonal interactions between the two, affects the quality of the relationship. Subsequently, the major theme “what to name it” is addressed incorporating the sub-themes pertaining to the participants’ theoretical understandings of alcohol abuse and alcohol dependence and the nurses’ attitudes towards alcohol use. If the relationship is trusting, and the screening and assessment have been effective, an unanticipated alcohol withdrawal will not occur and a good patient outcome is likely. However, nursing care may be interrupted or compromised should the alcohol dependent patient “slip through” the screening and assessment processes undetected. This may be the result of competing health concerns. When an event such as alcohol withdrawal occurs, the nursing care plan must be adapted to include the management of the patient’s symptoms of acute alcohol withdrawal that often result in safety concerns for the patient and the nurse. This results in both the patient and the nurse being at risk: the major theme “getting the brunt of it” arises out of the participants’ characterization of the experience.

The final section of the hospitalization story is entitled Patient Teaching for At-Risk Alcohol Use, and concerns educating the patient about at-risk alcohol use. Patient teaching about alcohol use may occur during initial screening and assessment or during other sections of the nurse-patient hospitalization story. The major theme, “opening the door”, is discussed as consisting of the stage during which the nurse and the patient negotiate the purpose and the content of patient teaching concerning at-risk alcohol use. In some cases, the nurse may
propose support and the patient may be receptive to the offer; or, the patient may not be receptive and may instead reject the offer outright. In other instances, anticipating that the patient is unlikely to be receptive, the nurse may decide that it is fruitless to put forward an offer of teaching or support. In such circumstance, particularly pertaining to teaching the elderly patient, the sub-theme of “locking out the elderly” emerges in this final section of the hospitalization experience.

Section One: Beginning the Nurse-Patient Relationship

A patient who is newly admitted to hospital experiences many transitions. As this hospitalization story unfolds, much will depend on how the nurse-patient relationship develops. Both the patient’s and the nurse’s individual characteristics such as personality, experience, and values, will affect the encounter. However, the fundamental capacity of the patient to contribute to such a relationship will also be affected by a number of stress factors. The patient faces change in health status, to which the admission to the medical or surgical unit attests. In addition, the patient is in unfamiliar surroundings, and is surrounded by many strangers: nurses, physicians, technicians, other hospital staff, and fellow patients. The patient may be too ill or in pain to make sense of their circumstances (Burns & Adams, 1997).

The nurse-patient relationship differs from those that develop in other contexts for two important reasons. First, the nature of the power relationship between patient and nurse necessitates particular vigilance on the part of the latter. Also, the nurse is more likely than the patient to have training in, and knowledge about, how to develop such a relationship.

Scholars have extensively studied the unique nature of the nurse-patient interactions, and recognize the role of the nurse in setting the tone for the relationship during the patient’s hospitalization (e.g. McQueen, 2000; Morse, 1991; Peplau, 1992; RNAO, 2002). Furthermore, if the nurse is able to lay a foundation for trust and begins to establish a relationship with this
new patient, the nurse is undertaking an important step to ensure the success of the patient’s care and outcome.

The Therapeutic Relationship

In both nursing research and practice guidelines, there is a particular emphasis on the nurse’s role in creating the “therapeutic” relationship. Morse (1991) describes this as the “ideal” nurse-patient relationship in which – if the needs of the patient are not too great – the nurse can give care quickly and effectively. McQueen (2000) suggests that the nurses’ role is to develop a relationship that evolves into a therapeutic relationship, and for the most part, this study’s findings are congruent with this viewpoint. In addition, as Moyle (2003) notes, the nurse in such a relationship should meet the patient’s routine psychosocial needs related to “normal” fears about surgery and anaesthesia. In addition to these, however, there are additional concerns such as an acute alcohol withdrawal that the medical and surgical nurse needs to consider should a patient be using alcohol at high-risk levels.

When nursing the patient using alcohol at risk levels, participants noted that it is especially important to establish a trusting relationship. Specifically, should the nurse not detect the patient’s alcohol dependence, this oversight may put both the patient and the nurse at risk. Thus, participants in this study placed great emphasis on their attempts to establish a rapport so that they could gain the trust of their patients. Their perspective on the need to develop this nurse-patient relationship aligns with the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (2002) and the Registered Nurses Association of British Columbia (RNABC) Guidelines for Nurse-Client Relationships (2002), both of which indicate that the nurse-patient relationship should be based on trust, respect, and intimacy, with the appropriate use of power.
The participants in this study described their attempts to establish a relaxed, client-friendly atmosphere, and noted the importance of characteristics or strategies associated with the development of a therapeutic relationship. For example, one of the younger participants, who recently completed a bachelor of science in nursing degree, described being a warm, caring, and attentive listener as an important aspect of nursing practice. Peplau (1992) describes the personal qualities that contribute to the development of a therapeutic relationship as friendliness, confidence, and attentiveness. It was evident from the stories some participants told that these were the qualities they tried to convey in their attempts to establish patient rapport. While some participants expressed concern, compassion, and empathy for patients using alcohol at high-risk levels, other participants emphasized the patients' resistance to health behavior change and the patients' lack of accuracy in reporting amount of alcohol consumed.

The Unilateral Relationship

Participants noted that it was not always possible to establish a rapport with alcohol-dependent patients, and cited various challenges they might encounter in their attempts to do so. When they were unable to succeed in establishing rapport, the participants noted that there was a lack of trust on one side or the other. Morse (1991) identifies a unilateral nurse-patient relationship as one that occurs when there is a lack of commitment from the patient or the nurse, or both, and the relationship is therefore out of step.

A patient who is dependent on alcohol may be defensive, suspicious, aggressive, or abusive, and inclined to conceal alcohol use for fear that others may be judgmental (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003). The patient may have accumulated experiences of stigmatizing and censure; these responses are associated with diminished self-perception and social reaction on the part of the patient using alcohol at risk levels. The patient might avoid
discussing alcohol use with a nurse, and this mistrust could thus hamper the development of mutually trusting relationship. In contrast, a patient who uses alcohol at risk levels may be unwilling to place trust in the nursing staff and be inaccurate about alcohol use, a situation one participant described with a high-risk alcohol and drug user. The patient therefore may seem to present a challenge for the nurse who needs to establish a rapport, develop trust, and negotiate a therapeutic relationship.

When patients present as pleasant, approachable, clean, and attractive, nurses will likely find them easy to approach. Morse (1991) suggests that sometimes patients may be so repellent that nurses do not want to enter into a closer relationship. Thus, it is not necessarily patients who reject the therapeutic relationship, or who deliberately contribute to its failure. Patients may be receptive to a relationship with the nurse, but because of alcohol use may seem difficult, act hostile, exhibit poor impulse control, or have poor personal hygiene; any of these attributes may deter nurses. Participants referred to this tendency to be repelled when faced with unattractive patients; they related stories of patients who smelled bad, had no teeth, were abusive, or spat on staff members. In such cases, nurses had difficulty overcoming their revulsion, and this interfered with the development of a therapeutic relationship with these patients using alcohol at high-risk levels.

Based on the testimony of participants, the issue of trust – which is undeniably important in the therapeutic relationship – seems more contentious or elusive when the nurse is considering the patients' use of alcohol. One possible contributing factor is the tendency of nursing texts (e.g. Allen, 1996) to state that patients who abuse or are dependent on alcohol under-report their alcohol use; thus, nurses may be approaching the therapeutic relationship having been taught that patient testimony is unreliable in the case of alcohol screening responses. The findings of this study support the notion that when the alcohol-using patient's or the nurse's beliefs and attitudes about alcohol use interfere in the development of trust in either
party, or when the behavior of one of the parties towards the other is unsatisfactory, the therapeutic relationship will probably be diminished. In such a case, the patient and nurse will be unable to trust each other, and a unilateral relationship will be the result. Such a relationship is incongruent for both the nurse and the patient, with the needs of neither party being satisfied.

The Problem of Therapeutic Relationships with Alcohol-dependent Patients

Most of the participants were aware of the need to try to form a therapeutic relationship, and knew of the specific strategies and skills involved. Nevertheless, all of the participants seemed to find the point at which they had to question the patient about alcohol use to be a particular obstacle in the newly-formed relationship. Many found that they were very often unable to establish a trusting relationship with patients using alcohol at high-risk levels; thus, the findings indicated that they formed unilateral relationships instead.

Section Two: Screening and Assessment for At-Risk Alcohol Use

A person who uses alcohol at high-risk levels may not be aware, when admitted to hospital, that assessment frequently involves a total health status review including the amount of alcohol consumed. Therefore, full assessment, which will include a specific screening for alcohol use needs to be conducted. Typically, the nurse will use the CAGE Questionnaire (Ewing, 1984) to obtain the necessary information, and as part of the screening procedure, the patient is asked a series of questions prescribed by this tool. Depending on the patients' personalities, experiences, and values, they may react in a variety of ways, but their responses will also depend on the manner in which the nurse asks the questions. That is, the way the nurse approaches the patient with the screening tool can influence the willingness of the patient to respond, and may affect the content of the patient's responses as well.
The patient may be ready to trust the nurse doing the assessment, recognize that the questions pertain to the nurse's desire to ensure health and safety, and feel comfortable answering the questions truthfully. Alternatively, the patient may perceive inquiries about alcohol use as intrusive, inappropriate, overly personal, irrelevant, or judgmental. If the patient feels threatened or offended by the questions, does not trust the nurse, or feels the nurse does not trust the patient, the patient may be disinclined to supply an honest answer. Thus, when a nurse broaches the subject with the patient, the way the nurse does so may have a bearing on the accuracy of the information the patient is able to provide. The nurses who participated in this study describe a successful screening and assessment as one in which the patient was accurate about alcohol intake and hence the likelihood of a good outcome was ensured. The findings indicated a poor outcome may result when a patient is not willing or unable to accurately disclose alcohol intake and an undetected and therefore uncontrolled alcohol withdrawal ensues.

**Working with the CAGE Questionnaire**

One of the reasons a patient may experience an unanticipated acute alcohol withdrawal is an unsuccessful screening and assessment for high-risk alcohol use. All the participants used the CAGE Questionnaire (Ewing, 1984), which is embedded in the initial nursing assessment form. The CAGE Questionnaire was the only screening tool the participants were aware of, and most felt that it was the best way they knew of to screen patients for alcohol use, although some added the proviso that they had difficulty administering it. For instance, some felt it necessary to alter the questions, or present the questionnaire after engaging in a preliminary discussion with patients about concerns for their health, personal safety, and comfort should they be using alcohol at risk levels.
All the participants were acutely aware of the consequences of an unsuccessful screening and assessment. They described experiences of giving care to patients with an unanticipated, acute alcohol withdrawal that progressed to delirium tremens. These experiences led to reservations about the CAGE screening tool, despite the fact that it is generally acknowledged to be the best available tool in the acute care setting (Mayfield, McLeod, & Hall, 1974; Buchsbaum, Buchanan, Centor, Schnoll, & Lawton, 1991; NIAAA, 1987; Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003).

When a nurse is able to identify a patient as being at risk for an acute alcohol withdrawal, the nursing staff is forewarned and able to initiate the appropriate withdrawal management protocol. The participants' testimony suggests that the screening and assessment procedures currently used do not ensure the identification of such patients; the standard nursing assessment does not include questions designed to elicit all necessary information pertaining to alcohol use. In addition, although the CAGE Questionnaire is embedded in the documentation form, it has no designated area to place the score obtained from the CAGE Questionnaire. Nor does the assessment require nurses to interview patients for frequency and quantity of alcohol consumed, although this is key information to an accurate and complete assessment (National Institute on Alcohol Abuse and Alcoholism, 1995). Because of the format of the assessment, participants, on their own initiative, asked questions about quantity and frequency of alcohol use. They also asked questions they had devised such as “do you have any alcohol at home?” after the CAGE questions, as some scholars recommend (Conigliaro, Reyes, Parran, & Schulz, 2003). Steinweg and Worth (1993) found that the CAGE tool was significantly less sensitive when administered after quantity/frequency questions, but those participants who posed their additional questions first were apparently not aware of this possibility.
"Slipping Through"

The study participants also questioned the sensitivity of the CAGE tool, based upon their experiences. That is, sometimes clients screened using the CAGE Questionnaire were not found to be at risk, but subsequently went on to experience an undetected alcohol withdrawal. Some of the participants, who were dissatisfied with this instrument, had developed their own questions to screen for alcohol use. Clearly, the deficiencies that participants perceived in the standard assessment procedures and screening tools such as the CAGE meant that they felt it necessary to rely on whatever experience, knowledge, training, and intuition they were able to bring to their patient assessments. This finding – that participants found the CAGE inadequate in screening for at-risk alcohol use and developed their own methods for detecting such use – is not consistent with the research that suggests the CAGE tool is a useful and highly accurate screening instrument. The participants related examples of an undetected alcohol dependence that proceeded to an acute alcohol withdrawal leading to delirium tremens; their perception was that patients were “slipping through” undetected; this suggests an area of concern as there are adverse effects on both the nursing practice environment and patient outcomes.

According to Ewing (1984), the CAGE Questionnaire was developed specifically to detect alcoholism (the alternative term now in common use is “alcohol dependence”). However, a further application of this tool may be to facilitate a discussion between the nurse and the patient about alcohol use. The nurse may find that although the patient’s alcohol use is not sufficient to indicate a pending acute alcohol withdrawal, the patient may be using alcohol at a level that warrants further investigation. Sullivan (1995) suggests that when a health care provider does not act on a finding of at-risk alcohol use, the patient may receive a false impression that his alcohol use is at an acceptable level and does not warrant follow-up or discussion. The act of screening, Sullivan further suggests, entails an implicit responsibility to act on positive findings and provide further treatment suggestions. Some of the participants,
however, felt that they wanted patients to demonstrate their readiness to receive information, without which indication they were hesitant to offer educational support to the patient. This finding suggests that nurses may disagree with the premise that Sullivan espouses.

However, it is important to note that the participants’ clinical decision making involved consideration of several competing factors that they perceived as being more urgent. Such factors included pre-operative teaching involving deep breathing and coughing exercises and the operation of technical equipment such as the patient-controlled analgesia system.

One of the findings of this study is that participants found the CAGE Questionnaire screening tool challenging to use for a variety of reasons. Some of these challenges related to the nurses’ knowledge deficits, including application of the tool and its scoring. The majority of participants’ concerns, however, related to the wording of the CAGE questions. Concerns included participants’ perception that the wording was too “in your face”, that is, overly blunt or awkward, and therefore caused discomfort for the patients and the nurse. The participants did not perceive that there were other useful options to the CAGE: even though the questions were difficult to ask, participants indicated that the tool was better than “beating around the bush”, “better than nothing”, or “a good starting point”.

Some participants felt that the questions in the CAGE provoked defensiveness and resistance, often even when the nurses were very careful in their approaches to the patient. Prior to the use of the CAGE Questionnaire, the participants experienced anxiety and anticipated the patient’s defensiveness. There were various strategies that the participants used in their attempts to ameliorate the undesirability of the CAGE Questions. For example, some emphasized efforts to develop a comfortable relationship with the patient, as described earlier in this discussion of the findings. In addition some chose to ask the questions in an order that they felt better suited the situation, even casually incorporating them into an informal conversation. Some participants believed they would jeopardize the sensitivity of the tool by not
asking the questions in a specific order, there is research that suggests the sensitivity and reliability of the tool does not decrease with this practice (Ewing, 1984). Other participants asked the CAGE questions in isolation, interspersing these into their conversations with patients, and some even felt it necessary to rephrase the questions, in the conviction that the results they got were better than with the original, unaltered tool.

There were other ways in which participants’ opinions about screening differed. For example, there was a discrepancy in the participants’ understanding of the exact CAGE Questionnaire score that would indicate potential for an alcohol withdrawal. Some nurses adhered to the view that a score of two identified a patient who was at risk for alcohol withdrawal – the original research suggested this score warranted further investigation regarding alcohol use (Ewing, 1984). Other participants believed that a score of one was sufficient to indicate a possible alcohol withdrawal; this view is in keeping with more recent research that suggests this lower score is the threshold at which the patient’s alcohol use warrants further investigation (Buchsbaum, Buchanan, Welsh, Centor, & Schnoll, 1992). As widespread as the use of the CAGE tool is, it was somewhat surprising to find that there was such a substantial difference of opinion among participants with respect to interpreting patients’ scores.

Although the research suggests that CAGE screening tool is accurate (Inciardi, 1994), effective (Mayfield, McLeod, & Hall, 1974; Buchsbaum, Buchanan, Centor, Schnoll, & Lawton, 1991; NIAAA, 1987), easy to use (Allen 1996), or the best available (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003), the participants generally disagreed, noting that they found it difficult to administer and were not convinced that its screening sensitivity was adequate. The strong difference in their perspectives of validity and sensitivity may be related to their application of the tool or some other factors that are not immediately apparent. The fact that this finding is not in keeping with perceptions of the CAGE as presented in the literature
suggests that there is still much to be investigated about the ways in which nurses use this tool in their practice.

**Incentives to Disclose during Assessment**

In negotiating the nurse-patient relationship, the participants noted, they needed to offer rationale to encourage the client to share information regarding alcohol use. In the context of post-operative pain management, for example, the participants informed patients that they did not want them to experience any suffering, and wanted them to remain safe. In so doing, participants attempted to help the patient to understand the link between supplying information and better outcomes during their hospitalization. That is, incentives to share information regarding alcohol use relate to two important patient concerns: being safe and being pain-free. Ensuring patient safety and providing pain control were issues central to the participants' practice experience; they also described these as concerns about which they were well informed and able to provide patient information.

One finding of this study that concurs with other research was the challenge of identifying the elderly patient using alcohol at risk levels (Curtis, Geller, Stokes, Levine, & Moore, 1989; Geller et al., 1989). For example, Willenbring, Christensen, Spring and Rasmussen (1987) found that elderly patients were particularly difficult to screen for substance use, and alcohol use was “hidden” as well as “neglected”. The participants reported that it was a challenge to encourage older adults to relinquish information regarding their alcohol use; they therefore found it particularly difficult to recognize at-risk alcohol use in the elderly patient.

**Nursing Education for Screening**

The results of this research indicate that participants exhibited a knowledge deficit regarding the CAGE screening tool related to the tool's purpose, application, and interpretation.
Based upon the participants' concerns about the tool and the anxiety and discomfort they experienced both when administering the tool and from the subject matter itself, there was need for the participants to increase their knowledge base. They clearly expressed the belief that these deficits would best be met within basic nursing education as well as ongoing teaching and learning about the application of the CAGE tool and information regarding alcohol abuse and alcohol dependence. Aside from a brief discussion of the CAGE Questionnaire (as part of the nursing assessment form) which took place at during orientation to the agency, the participants noted that there was no education provided on a routine basis. As a result, the participants found they had limited (if any) access to knowledge from an informed source; the only such source of knowledge was from co-workers – who may or may not have been using the tool as it was first designed to be used, and whose perceptions of alcohol use may fall into as wide a range as those of the participants themselves.

The participants in this study expressed the perception that, in addition to having insufficient education about alcohol screening and assessment, they did not have appropriate support at the organizational level to be certain that they are using their screening tools optimally. Additionally, they felt that they were not well equipped to intervene when they identified patients who were using alcohol at risk levels. This finding is significant and suggests that there is a knowledge gap concerning nurse-patient interactions during screening, assessment, nursing, and intervention for patients who use alcohol at risk levels. Based upon the examples provided by the research participants, screening and assessing for alcohol use is a sensitive subject that requires delicacy and tact. However, as nurses address sensitive issues such as alcohol use, they seem sometimes to revert to social communication skills from earlier phases of nursing, when patient discussions were limited and superficial (Macleod Clark, 1983). Participants seemed to be aware both of the substantial requirements of the screening
Section Three: Negotiating the Nurse-Patient Relationship

All nurse-patient relationships are concerned with negotiation or interaction between the nurse and the patient. Morse (1991) suggests the intensity of the negotiation depends upon the patient’s perception of the seriousness of the situation and the patient’s feeling of vulnerability and dependence. That is, once the nurse has established a relationship with a patient and has completed a screening and assessment, the ongoing relationship between the two not only affects the patient’s care, but also is itself affected by the context of the nurse-patient relationship. Although the patient is not a passive recipient of the nurse’s attentions; again, as in the previous phases of the developing relationship, the nurse has a more substantial role than the patient in attempting to ensure that the relationship is therapeutic, as is appropriate for the maximum benefit to the patient. It is the nurse’s responsibility to ensure that the relationship with the patient is therapeutic and professional (RNABC, 2002).

At this point in the story of this relationship, the nurse would have an opportunity to perform an appraisal of the patient in an effort to determine the nature of the patient’s needs; the nurse is in a position to make a personal decision about further investment in the relationship with the patient. The past experience, knowledge, and attitudes of the nurse as well as the personal attributes of the patient may influence the extent to which the nurse is willing to engage with the patient. Morse (1991) notes that this assessment is one that is different than and occurs separate from a routine nursing assessment. Such an assessment is not performed from the perspective of health assessment, but as a general information gathering process. This assessment addresses the needs of the therapeutic relationship rather than the medical needs of the patient, and it entails the nurse evaluating the patient’s personal needs and support system,
assessing the patient as a person, and consciously choosing whether to make an emotional investment in the patient or perhaps to "just do the job". Some participants in this study described processes somewhat similar to the one Morse describes, including creating rapport with their patients. The participants actions were consistent with to those Morse describes as "establishing common ground with the patient in an attempt to entice the patient to become more involved" (p. 461). The participants described making an effort to put the patient at ease, to create an intimate atmosphere conducive to disclosure, to keep their discussions "light" (that is, non-threatening) and on occasion, to divulge personal information. Most participants believed that when patients felt that the relationship with the nurse was secure, they would be able to relax vigilance and divulge information regarding alcohol use. The participants described their overtures toward patients as necessary steps in the process of obtaining information about alcohol use. Hence, despite the apparent similarities, participants did not seem to engage in the process that Morse describes; in fact, a number of factors seemed to interfere with these participants' ability to negotiate their ongoing relationships with their alcohol-using patients. Among these were the participants' perceptions of their patients' fears, resistance, and defensiveness, their own underlying beliefs and values, participants' unwillingness to trust the patients' disclosures, and certain practice factors such as a lack of consensus on the nature of at-risk alcohol use, concerns for safety, and insufficient nursing education.

Participants' Perceptions of Patients' Reluctance

Study participants expressed concerns that their patients with alcohol-related problems, felt vulnerable and feared social labeling (being identified as "an alcoholic" or "having a drinking problem"). They noted that such fears might cause patients to avoid discussing their intake of alcohol even when failing to disclose the information would affect their access to
appropriate health care services. These views align with the findings of a recent study by Sieck, Heirich and Major (2004). The findings of this study suggest that participants' perception of their patients' feelings might have some validity. It is not clear from the results of this study, however, the extent to which participants projected their own values onto participants, and to what extent they accurately reflect the way patients felt about their alcohol use.

The study findings revealed that some participants did not endorse the disease perspective of high-risk alcohol, opting instead for the moralistic and psychological perspectives. Therefore, although most expressed a desire to relate to their patients and help them, the underlying values of some participants (reinforced by negative experiences with patients in acute, undetected and uncontrolled alcohol withdrawal) seemed to support the notion that it is appropriate to question the validity of the information patients provide, and also the idea that offers of patient education should await request for such from patients. Some comments reflected a tendency to engage in social labeling, and revealed that a moralistic perspective about at-risk alcohol use that may have been impacted by society's moralistic perspectives.

Social Reaction Theory, also known, as Labeling Theory postulates that when a person embraces a social label (and thereby a negative perception of members of a group such as "alcohol abusers") the label will influence the person's behavior (Becker, 1963). This is relevant to nurses who care for patients with alcohol abuse or alcohol dependence issues. Crandall (1991) suggests that once an individual is given the label of "senile", for instance, it is this label to which others will respond to first, and once the label has been applied it is difficult to change. This scholar further purports that a major challenge in successful recovery is coping with the stigma may people associate with alcoholism (Crandall). Labeling theory claims that labels affect both a person's own self-perception and other's perception of them, and that these internal and external perceptions channel a person's behavior into either deviance or
conformity. Society's tendency to assign labels such as "alcoholic" and "drunkard" that stigmatize an individual who abuses alcohol is a factor that could impact the nurse-patient relationship. Stigma is associated with feelings of self-perception and societal reaction (Goffman, 1986) and may affect the individual's disclosure of alcohol use to health care professionals. Lowe (2000) describes stigma for the substance-using individual as a combination of the patient's attitudes, the healthcare workers attitudes involved with them, and societal judgments about individuals who use substances. As Eliason and Gerken (1999) note, nurses are socially acculturated with the same predominant values as the general population. They are susceptible to the same biases, judgments, and denials. The finding of this study confirms this.

In addition to personal and ethical values, the participants had presumably also been exposed during their nursing education to current medical knowledge about alcohol abuse and dependence. Although the dominant perspective in the medical literature is that alcohol dependence is a disease, there are moral overtones in health care providers' approaches to alcohol use, a perspective that suggests alcohol use is related to will power or moral weakness (Eliason & Gerken, 1999). Participants were aware of the disease perspective of alcohol abuse, but reported they were not convinced, and others reported that they disagreed with this theory. The theoretical lens through which the nurse views alcohol abuse and alcohol dependence has an impact on the nurse-patient relationship. Hughes (1989) suggests that at the onset of any helping relationship, both the substance abuser and the nurse hold a set of assumptions about the patient's problem as well as what can and should be done to correct it. Without a common theoretical understanding of alcohol abuse and alcohol dependence, "it is difficult for nurses (or indeed any health care provider) to be certain of how best to address the health care needs of patients" (Hughes, p.10). Definitions and theoretical approaches have been influenced markedly, not only by varying beliefs about etiology, but also by historical perspectives of
addictions (Allen, 1996). Confusion exists as to what services to provide and the role of nurses in providing the services. Participants found it difficult to negotiate a positive, fully supportive, trusting relationship with their patients. Nevertheless, patient outcomes were affected by these difficulties and discrepancies, and it was clear that participants were frustrated by these circumstances. The findings of this study lend support to the notion that addressing the health care needs of patients experiencing alcohol abuse and alcohol dependence challenges the nurse-patient relationship in ways that are unique compared with the circumstances of most other health conditions.

Interpersonal Factors

One important finding of this study relates to the participants' interpretations of their patients' reporting of amounts of alcohol consumed. It was a common understanding among the participants that patient information was rarely accurate about the amount of alcohol consumed. Consequently, the participants were nearly unanimous in their agreement that they had to automatically double the reported amount to arrive at a correct figure for the patients' alcohol use. One nurse summed up this widespread perception among participants that patients almost invariably underreport, as: “an age-old story... if they tell you they have two drinks, they have had four”. Thus, when the nurses felt unable to trust their patients' testimony, these relationships were clearly unilateral in the sense that Morse (1991) describes. The research literature does substantiate this specific finding of nurses' perception of chronic and consistent underreporting on the part of alcohol-using patients (Wallace, 1990). It is possible that the qualitative study methodology it is more likely to elicit such a finding than quantitative research. Since most of the research in the literature consists of quantitative studies, it is possible that the absence in the literature of findings similar to this one could be an artifact of the quantitative method. Moreover, since numerous quantitative studies suggest that a
moralistic perception of alcohol use was common among nurses, a tendency to question alcohol-dependent patients' information regarding alcohol use is perhaps likely to be a logical outgrowth of such perceptions. Further investigation using qualitative research methods may provide insight into these interpersonal issues.

Environmental Factors Influencing Nursing Practice

The environment that prevails in the practice setting is linked to the nurses' meanings and interpretations of alcohol use such as the lack of consensus concerning theoretical perspectives, stress in the workplace, and concerns for safety.

The findings of this study are congruent with the research literature reporting that there are diverse perspectives from which to consider alcohol abuse (Rowland & Maynard, 1989; Allen, 1993). As noted above, some participants considered alcohol dependence as a personality trait and described the use of alcohol as a coping mechanism. Both viewpoints are rooted in psychological theoretical perspectives of alcohol dependence (Rassool, 1998). The personality theory asserts that the patient's personality is influential in the development and maintenance of the disorder (Sher, Walitzer, Wood, & Brent, 1991). Some study participants suggested using alcohol was a coping mechanism to relieve stress. This belief is aligned with the tension reduction theory and is based upon behavioral learning principles. The tension reduction theory hypothesizes that: 1) alcohol or other drugs reduce tension, and 2) that individuals use alcohol or other drugs for their tension-reducing properties (Cappell & Greeley, 1987; Lazarus, 1977). The remainder of the participants viewed alcohol dependence either from the moralistic perspective, or from the disease perspective; very few embraced the latter.

It is important to note that none of the study participants subscribed to either the biospsychosocial theoretical approach or the holistic model, a current holistic approach used in nursing practice. Together with the biological, psychological, and social perspectives
underlying addiction, the holistic model brings forth new understandings of chronic disease and its impact on addictive behavior. There continues to be a significant gap between research and practice as the participants did not reveal any awareness of either of these current approaches that provide direction for treatment planning (Mulhall, 1997; Seymour, Kinn, & Sutherland, 2003). Whatever the theoretical perspective of the individual nurse, the nurse-patient relationship is complicated by the lack of consensus as to what to or how to define alcohol abuse and alcohol dependence. The result is a lack of a unified plan or understanding as to how nurses can support health recovery.

Other practice environment factors that can affect the relationship between nurse and patient include the heavy workload and job stresses that are characteristic of the nursing practice environment today (Moyle, 2003). For example, while a patient may naturally anticipate that the nurse will be a caring, understanding and trusting person, this may not always be the case. In pressurized situations when nurses are short of time and have many patients to care for, their feelings of being rushed and harnessed with a heavy workload can override their feelings for individual patients. Without due attention these can spill over into the nurse's manner and behavior with patients (McQueen, 2000). While the participants did not specifically refer to workload, their comments allude to significant stresses in the practice environment, and the findings suggest that participants' stress contributed to difficulties in establishing trusting relationships with patients. A further issue that arises due to staffing pressures is that there may be several nurses providing care to a patient, so that when screening and assessment is most critical in detecting at risk alcohol use, no one nurse is consistently caring for the patient and building the patient's trust (Burns & Adams, 1997). Again, participants did not refer to this situation specifically, but some did refer to the difficulty of establishing rapport with only brief interactions. One participant did note that extra time spent in conversation with a patient was valuable in promoting trust.
The most difficult issue that participants faced was a risk of personal injury at the hands of patients in acute alcohol withdrawal. With the exception of one participant who was a newly qualified nurse, all the participants described situations in which they had experienced injury, or abuse, or both, as a result of their patients' disruptive behaviors associated with delirium tremens, seizures, and/or confusion. In defining the various categories of violence, participants in this study referred to categories similar to those described by Hesketh et al. (2003). The participants experienced physical assault such as being spat on, bitten, and physically struck. Verbal threats of assault were frequent; one participant received death threats, and others were threatened with physical harm. Verbal abuse included screamed obscenities and being called a variety of unsavory names. The participants experienced emotional abuse through patients' hurtful attitudes and insulting remarks. One of the participants acknowledged the emotional trauma experienced when patients needed to be restrained, causing a great deal of anxiety believing it to be in violation of the patient's rights.

Recent research studies have found that within health care facilities, health care workers are subjected to violence perpetrated as a result of changes in rules and regulations governing access to health care and early discharge from healthcare agencies (Smith-Pittman & McKoy, 1999). Although the majority of the research literature investigating violence in nursing has been concerned with psychiatric and emergency settings, the findings of other studies confirms that nurses are at risk no matter where they work (Levin et al, 1998). Fernandes, Bouthillette, Raboud, Bullock, Moore, and Christenson (1999) identified the medical and surgical settings as being at high risk for workplace violence. A recent study of hospitals in Alberta and British Columbia found that the highest level of physical assaults was reported in medical and surgical units (Hesketh et al., 2003); the study also found that 90% of physical assaults and threats of assault were attributed to patients and 4.8% were attributed to family and visitors. Within a five-day period, the study noted, 33.8% of nurses reported physical
assault, 36% reported threats of assault, and 29% reported emotional abuse. The findings of this study lend support to the notion that medical and surgical nurses are at extremely high risk for violence. Although this study does not identify the etiology of the violence occurring on the medical and surgical areas, some researchers (e.g. Levin, Hewitt, & Misner, 1998) have identified substance abuse and psychiatric disorders as the main factors contributing to violence in the emergency area. Based upon these findings, changes in environmental support need to occur.

**Undetected Alcohol Withdrawal**

The findings of this study suggest that when patients are violent and abusive, it is difficult for nurses to maintain an empathetic attitude. Thus, when a patient's alcohol dependence is undetected and an alcohol withdrawal occurs, the consequences are generally such that it makes caring for an already stigmatized population much more difficult. It is very likely that the participant's inability to trust their patients reporting of alcohol use was related to the devastating effects on both patient and nurse when a withdrawal occurs. Complicating this may be the fact that, as participants noted, they have concerns about the efficacy of their own use of screening tools and procedures, as well as concerns about other staff members' ability to screen effectively. The nurses' tendency to distrust patient's reporting of alcohol use may have been perceived by the patients, thus undermining the possibility of promoting the trust that is necessary for accurate disclosure of alcohol use. The finding that most participants believed that their patients drank at twice the amount they reported may be an example of nurses “err[ing] on the side of caution” in an effort to ensure nurse and patient safety. It is not possible to argue that such an approach is appropriate or accurate, for there is no “formula” for the amount patients underreport. This finding thus strongly suggests systemic deficiencies in
the way patients are screened for alcohol use, and suggests that these processes need to be investigated more extensively.

Section Four: Patient Teaching for At-Risk Alcohol Use

When a patient using alcohol at risk levels presents to the medical and surgical setting, the initial diagnosis may appear to be unrelated to alcohol use. A patient may present with nonspecific complaints such as: dyspepsia, nausea, diarrhea, gastroesophageal reflux disease, anorexia, and recurrent minor traumas such as falls (Graham, Schulz, Mayo-Smith, Ries, & Wilford, 2003). The patient may be unaware of the health consequences of at-risk alcohol consumption, or may deny that the consequences are alcohol-related. The patient is therefore not likely to expect a nurse to offer education or suggestions for treatment for at-risk alcohol use. Nevertheless, it is during such hospitalizations that screening and assessment for at-risk alcohol use could interrupt the patient's addictive disease cycle at perhaps an early stage of development. The earlier an alcohol-related problem is identified and treated, the easier it is to attain a positive outcome as both biomedical and psychosocial factors are less entrenched, making it easier for the patient to accept counseling and treatment (Minicucci, 1994). As the disease process continues, a number of outcomes attributable to high-risk alcohol use may emerge. These include gastrointestinal bleeding, pancreatitis, liver disease, or withdrawal seizures (Graham, Schulz, Mayo-Smith, Ries, & Wilford, 2003). Although many nurses are strategically positioned to screen for at-risk alcohol use and to offer interventions, one of the findings of this research was that participants provided little patient education or sharing of important information pertaining to alcohol use.
Nurses' Identified Patient Teaching Practices for At-Risk Alcohol Use

When the participants did address the alcohol use of patients, it was specifically in the context of the patient's current hospitalization. For example, from the perspective of a surgical operation, the participants discussed alcohol use in terms of potential surgical complications and subsequent medication management. Several participants cited contextual issues curtailing their ability and the patient's willingness to engage in patient teaching related to at-risk alcohol use. These concerns addressed the delivery of nursing care provided by more than one nurse thereby inhibiting the establishment of a consistent therapeutic relationship key to discussing issues related to alcohol use. Further contextual issues concerned the view that some patients were already overwhelmed managing their current hospitalization experience (i.e. surgery) and too ill to enter into a patient-teaching discussion regarding alcohol use. Systems issues concerned the lack of best practice guidelines would focuses on a systematic plan of care during hospitalization and upon discharge from the acute care setting.

Savage (1996) suggests that embedding the CAGE Questionnaire in the context of a general nursing assessment naturalizes discussions about alcohol abuse and alcohol dependence and thereby encourages an open discussion. The comments from these study participants suggest that embedding the CAGE in the general nursing assessment did not have this effect.

Only one study participant (a newly qualified BSN nurse) used the CAGE screening tool as an indicator to gauge whether the patient was receptive to talking about alcohol use. This participant would monitor the patient's reaction when asked the CAGE questions, and if the patient expressed some interest in knowing more about alcohol use, the nurse stated that such a discussion would ensue. If the patient had a negative reaction or became defensive, the participant did not attempt to discuss alcohol use. The remainder of the study participants did not engage in any discussions about alcohol use unless the patient provided an indication of
receptivity in discussing the subject. Based on this “patient must open the door” criterion, only two participants engaged in discussions related to alcohol use, and these involved encouraging the patient to attend Alcoholics Anonymous meetings as access to a “treatment service”. One participant briefly described residential treatment, but was unable to provide any specific information regarding a particular facility.

**Patient Teaching with Older Alcohol-Dependent Patients – A Special Case?**

There were some differences in the way participants viewed older alcohol-dependent patients as compared with younger alcohol-dependent patients. Participants believed that it would be better to maintain the older adult on alcohol rather than initiate a planned alcohol withdrawal. A sub-theme was identified and described as “locking out the elderly”; this sub-theme related to patient teaching strategies. The participants were pessimistic about the likelihood of the older adult being able to abstain from alcohol use in the long-term. Some scholars suggest that at-risk alcohol use is detrimental to, and poses a even greater health risk for, older patients as compared to younger age groups (Dufour & Fuller, 1995); however, some of the participants seemed to consider that, based upon their age and life experience, using alcohol was a “deserved right” and “right of passage” for older patients. Therefore, it was not surprising that the participants who felt this way did not engage their older patients in patient-teaching experiences. A participant suggested that an alternative approach to caring for alcohol-dependent patients was to simply allow them to “have their alcohol”. There are health care jurisdictions in which a tolerant approach to alcohol is the norm, and patients have traditionally been permitted to have some alcohol, for example, wine with meals (France and Italy) or stout for nursing mothers (U.K.). Given the findings of a substantial number of studies that moderate alcohol consumption has health benefits, the practice of banning all alcohol under all circumstances from North American hospitals suggests that the moralistic perspective
guides decisions rather than any systematic, medical analysis of the best approach. This participant's suggestion may deserve further investigation. It is interesting to note that participants drew a sharp contrast between the older adult and the younger patients. Further research into this apparent double standard may provide insight into the attitudes of nurses towards their patients who use alcohol, whether older or younger.

**Limiting Patient Teaching Initiatives Regarding At-Risk Alcohol Use – What's Missing**

Although the CAGE affords an opportunity for the nurse to openly discuss at-risk alcohol use, participants of this study limited their use of the CAGE Questionnaire only to screening for an acute alcohol withdrawal. Without discussing health outcomes attributed to at-risk alcohol consumption, the patient's alcohol use patterns remain unrecognized and the harmful effects may potentially escalate. A proactive approach to patient teaching would better serve the patient's health needs. In serving the patient's interest, the nurse would identify and address at-risk alcohol use earlier rather than later and possibly limit the progression of the disease (Cook, Back, & Trudeau, 1996; Richmond, Kehoe, Heather, & Wodak, 2000). In relation to patient teaching regarding at-risk alcohol use, the participants seemed to adopt the moralistic perspective that purports that the patient has to "reach bottom" before addressing teaching initiatives.

The study suggests participants were unaware of their own role in limiting the access of patients to alcohol-related information. To the participants, it was the patient's responsibility to "open the door"; without this encouragement on the patient's part, the participants would not offer information on the effects of alcohol on bodily systems that could have an impact on the patient's current and future health status. Participants did not seem prepared to offer information such as a review of the Canadian low-risk drinking guidelines (see Appendix A), whereby the nurse facilitates the patient's awareness of the possibility of lessening the harmful
impacts on health by consuming alcohol based upon established low-risk amounts. Patient teaching initiatives could be further developed by including various harm reduction strategies to lessen the harm associated with at-risk alcohol use, such as reserving one day per week to be free of alcohol consumption (Heather, 1996; Finfgeld, 1999). Based upon the participants’ discussions regarding patient teaching pertaining to at-risk alcohol use, they were unfamiliar with the concept of the “brief intervention” which may involve a short assessment, concise feedback regarding assessment findings, and succinct counseling to focus on helping individuals change at-risk drinking habits (Finfgeld).

In conclusion, by limiting alcohol-related discussions, participants missed opportunities to offer patient teaching. A key finding, then, is this hesitance on the part of participants to engage the patient in teaching discussions about alcohol use. These findings concur with other research similar to other disciplines (Sieck, Heirich, & Major, 2004). Further investigation of the extent and factors that impact the nurses’ in addressing patient teaching regarding at-risk alcohol use would help to provide insight into this important issue.

Summary

The findings of this study furthered a deeper understanding of the meanings and interpretations medical and surgical nurses attributed to alcohol abuse and alcohol dependence. By following the “story” representing a hospitalization experience and subsequent development of a relationship between a nurse and a patient, the major themes and the sub-themes found in the research findings are explored and described to add a deeper meaning and understanding of the experiences of medical and surgical nurses. The findings suggest that such meanings and interpretations may underlie certain systems failures that also may be factors in patient outcomes. For example, participants rejected the disease perspective and instead subscribed to a moralistic one. A link between underlying values or beliefs and nurses’
behavior towards patients is supported both by the findings of this study and is consistent with the literature.

There were knowledge deficits in the participants’ understanding of high-risk alcohol use, in their familiarity with current research and practice issues related to alcohol use, and in their knowledge of the purpose, application, and scoring of the CAGE Questionnaire. This suggests that basic and ongoing nursing education needs to prepare nurses adequately in a number of areas related to nursing patients using alcohol at high-risk levels.

Overall, there were also discrepancies in participants’ views, meanings, and interpretations of alcohol use, which appear to reflect the overall lack of consensus in the health care field in general, with respect to both theoretical and practical approaches to the alcohol-using patient.
CHAPTER SIX: SUMMARY AND CONCLUSIONS

This final chapter of this research study provides a summary of the research purpose, methodology, reports the study findings, identifies implications for nursing practice, education, administration, and finally, offers suggestions for future nursing research.

A Summary of the Study

The original impetus for this research study was my awareness that many health care professionals do not recognize, diagnose, or treat their patients’ at-risk alcohol use. Since I was aware that early identification and intervention of at-risk alcohol use could potentially interrupt the addictive disease cycle, I became interested in knowing more about what it was about this health condition that caused it to remain unrecognized, undiagnosed, and untreated. As a result of this realization, I became interested in learning more about why patients in medical and surgical contexts with alcohol abuse and alcohol dependence may not be provided with care aimed at improved health outcomes.

This study was designed to study this phenomenon from the perspective of medical and surgical nurses – the largest demographic of practicing nurses – to learn about their nursing experiences with patients using alcohol at risk levels. The purpose of this qualitative research study was to explore and describe the meanings and interpretations attributed to alcohol abuse and alcohol dependence as described by medical and surgical nurses. In keeping with this intent, the qualitative research approach of interpretive description was chosen. Nine medical and surgical nurses were interviewed and rich data was obtained. Using inductive analysis themes and patterns were identified. Five major themes and twelve sub-themes emerged to describe the experiences of medical and surgical nurses providing nursing care to patients using alcohol at risk levels. The major themes that emerged were:
(1) Establishing the Nurse-Patient Relationship: identified the necessity and importance of establishing the nurse-patient relationship;

(2) What to Name It?: described the ambivalence and lack of consensus regarding how to name or classify alcohol abuse and alcohol dependence;

(3) Slipping Through: identified issues related to alcohol dependence not being recognized so the patient experiences an unanticipated alcohol withdrawal;

(4) Getting the Brunt of It: described the nurses’ experiences of nursing a patient with an undetected acute alcohol withdrawal; and

(5) Opening the Door: described the perception that patients need to give nurses an indication that they are receptive to learning about alcohol use.

The sub-themes to emerge, linked to the major themes provided further explanation and understanding of the phenomenon:

(1) creating comfort and rapport; acquiring patient trust

(2) diverse theoretical perspectives; nurses underlying attitudes about alcohol use

(3) communication issues; working with the CAGE Questionnaire; attempting to elicit information

(4) concerns for patient safety; concerns for nurses and staff safety

(5) nurse-initiated patient teaching; patient reluctance; locking out the elderly

The discussion of the findings of this research study was presented in the form of a “story” consisting of four sections to represent a patient’s hospitalization experience. Within these sections, the themes and sub-themes were discussed and analysed. The themes and sub-themes were not mutually exclusive within the context of the story sections but interconnected with many aspects being interwoven within the sections. The sections of the story are identified as: beginning the nurse-patient relationship, screening and assessment for at-risk
alcohol use, negotiating the nurse-patient relationship and finally, patient teaching for at-risk alcohol use.

**Study Implications**

The findings of the present study illuminated several implications for nursing to enhancing nursing care for patients using alcohol at risk levels. These implications are directed at nursing practice, nursing administration, nursing education, and nursing research.

**Implications for Nursing Practice**

Implications for nursing practice concern the nurse-patient relationship, the range of theoretical perspectives whereby nurses consider alcohol use, screening and assessment processes, safety concerns for the patient and the nurse, and the delivery of patient teaching initiatives.

The therapeutic relationship is recognized as an important component for healing to occur, so to find an area in nursing practice where there is a barrier within the nurse-patient relationship, points to important implications for nursing practice. For the most part, participants did not consider their patient’s accounts of amounts of alcohol consumed as valid. Difficulties developing trust for either the nurse or the patient suggests a unilateral rather than a therapeutic relationship. In a unilateral relationship, neither the needs of the nurse nor the needs of the patient are met Morse (1991). In the absence of a therapeutic nurse-patient relationship acquiring accurate accounts of alcohol used is compromised. With developing an understanding of the context of at-risk alcohol use the nurses are facilitated in approaching the nurse-patient relationship with greater insight into the requirements to foster relationship building.
The diversity of theoretical perspectives from which it is possible to consider alcohol dependence limits cohesion in planning treatment guidelines. This interferes with the adherence to best practice guidelines and the provision of a unified plan of care to the patient using alcohol at risk levels. The psychological, moralistic, and disease perspectives of alcohol abuse and alcohol dependence do not offer nurses an explanation of the nature of alcohol use that is in keeping with current theoretical, research, and practice applications. Furthermore, these theoretical explanatory perspectives provide only minimal treatment direction applicable to the acute care setting. A specific concern of the moralistic perspective is that it is reflective of a negative and non-therapeutic attitude toward the patient using alcohol at risk levels. The most recent literature identifies the holistic model, which incorporates perspectives of chronic disease management based on the strengths of the earlier biopsychosocial model. This recent perspective from which to consider alcohol abuse and alcohol dependence could assist treatment planning and provide direction for more recent treatment strategies such as brief interventions applicable to the acute care setting. Better health outcomes could be facilitated with the adaptation of this model to support nursing practice.

When alcohol dependence is not recognized and therefore initially unmanaged, the experience of nursing the patient in acute alcohol withdrawal impacts nursing practice from several perspectives. An unanticipated alcohol withdrawal may occur as a result of inadequate screening and assessment or result from systems issues within the healthcare setting. An example of such a systems issue is the administration of the CAGE Questionnaire, which requires accurate administration to ensure validity and reliability. The participants identified concerns about this tool and acknowledged the difficulties experienced using it thus affecting patient care. A review of the CAGE screening tool is necessary to facilitate its administration and to ensure reliability and validity.
A prominent finding related to an undetected alcohol withdrawal pertains to the communication patterns with the medical staff, nursing co-workers, and patients. A further challenge of unanticipated alcohol withdrawal is the safety issues that arise for both the patient and the nurses providing nursing care. The implications for nursing practice of an unanticipated alcohol withdrawal are significant both for the patient in terms of their outcomes and the practice experience of the nurses. The nursing staff needs to be facilitated in identifying the patient at risk for alcohol use by facilitating communication practices and raising awareness among all members of the health care team.

A final implication for nursing practice is the patients' receiving limited teaching and sharing of information about at-risk alcohol use. The findings of this study suggest patient teaching activities were primarily focused on the patients' current hospitalization experiences. In the event patient teaching did occur regarding at-risk alcohol use the elderly patient group was not included. The current trend to advance health promotion initiatives was thus not supported in the case of the elderly patient and only minimally in terms of other patient groups in need of support for at-risk alcohol use. With increasing the nurses' awareness of their potential to effect patient change, it may prompt the nurses in addressing at-risk alcohol use with the client.

Implications for Nursing Administration

In order for the following implications to be acted on, a replication study is needed in a different context among a wider cohort as this study's finding may be isolated to the culture of the clinical agency and/or reflective of the age of the participants and their educational background.

This study points to implications for nursing administration at the clinical agency concerning the issues identified pertaining to the administration of the CAGE Questionnaire, the
agency's nursing documentation system, and support for nursing staff in nursing patients experiencing acute alcohol withdrawal.

The participants identified challenges regarding administrating the CAGE Questionnaire, their comments indicated that this screening tool may need to be reviewed as a useful tool to guide nursing practice. The CAGE Questionnaire was found to be limited as a mechanism to facilitate further patient treatment and education. A comprehensive set of implementation guidelines may be helpful to be more successful with the administration of the CAGE Questionnaire and address concerns related to its validity and reliability. In the absence of guidelines, the CAGE screening tool is vulnerable to individual interpretations, attitudes, and biases. Successful screening and assessment for at-risk alcohol use is warranted from the perspective of patient outcomes, nursing staff and patient safety, and subsequent escalation of health care costs.

A further implication for nursing administration concerns the nursing assessment form and the omission of a designated area to document the CAGE score and the omission of questions related to quantity and frequency of alcohol use. Accurate and accessible information is necessary for nursing staff to react in a timely manner in the event the patient using alcohol at risk levels experiences symptoms of an acute alcohol withdrawal. Overshadowing the nurses' practice were issues that arose in the context of their work setting in terms of the patients' and the nurses' safety in providing nursing care with little support administratively. The complex needs of the patient using alcohol at risk levels could be better met by establishing a multidisciplinary team. This team could provide expertise for screening and assessment procedures, withdrawal management, and subsequent treatment options. It would be appropriate for the team members to represent nursing, medicine, pharmacy, and social work disciplines. Team support would ensure the nursing staff is supported with a variety of discipline-specific knowledge and expertise. In supporting improved screening and assessment
processes, it would be possible to address acute alcohol withdrawal in a timely manner. The desired result would be to lower the frequency of episodes of unrecognized acute alcohol withdrawal. In addition, this supportive team approach would help to lessen nurses’ concerns regarding risks to personal safety and to the safety of their patients.

Implications for Nursing Education

This study’s findings point to implications for nursing education and pertains to the following: the way theoretical perspectives of addictive disease are considered and taught to nurses; to the nursing models that guide clinical practice; to the teaching of brief intervention treatment strategies; the role of the nurse in addressing at-risk alcohol use; and, education about patient teaching inclusive of health promotion strategies. Nursing education needs to address these knowledge deficits and therefore increase the confidence, knowledge, and skill of nurses in the practice setting.

The participants diverse theoretical perspectives regarding alcohol dependence identifies the need to educate and develop a unified perspective to enhance understanding of the complex set of determinants that impact addictive behavior. It is important that basic nursing education and continuous education sessions provide current theoretical knowledge of alcohol (substance) use. Education is required to increase the nurses’ awareness of biases and moral judgments that arise in practice such as social labeling. Knowledge of the holistic model of practice that incorporates perspectives of chronic disease management will further the nurses’ understanding of alcohol dependence and help to structure nursing practice to better meet the needs of the patient (Ministry of Health, 2004). Knowledge of the Transtheoretical Model acknowledging that health behavior change occurs over a period of time will facilitate the nurses in understanding the complex issue of behavioral change for the patient using alcohol at-risk levels (Connors, Donovan, & DiClemente, 2001). The participants identified
knowledge deficits pertaining to the application of therapeutic communication skills and all phases of alcohol withdrawal syndrome and its management. The participants also identified knowledge deficits regarding treatment initiatives including: brief interventions, Canadian low-risk alcohol use guidelines, and the effect of alcohol on a wide variety of health conditions. Another specific knowledge deficit was the participants’ beliefs concerning the elderly patient’s use of alcohol. Current knowledge of programs for this cohort needs to be included in nursing programs.

The utilization of health promotion strategies aimed at lessening the harmful consequences of at-risk alcohol use, can be very effective in reaching patients using alcohol at risk levels early in the addictive disease cycle.

Implications for Future Research

Based upon this research study, implications are identified for further research studies. It would be useful for subsequent research studies to explore the patient’s views and perspectives of nursing practice that are helpful in facilitating a health behavior change related to alcohol dependency. It would be informative to determine what nursing actions would (from patients’ perspective) successfully influence patients to consider a health behavior change or to encourage the adoption of health-responsive attitudes.

Further research is also required to study ways to develop and manage the multifaceted relationship between the nurse and the patient using alcohol at risk levels. By addressing the complexities that arise when attempting to establish a therapeutic nurse-patient relationship, barriers that occur in providing nursing care and accessing appropriate treatment would be lessened and thereby improving health outcomes.

Research is necessary to study the specific cohort of the elderly patients using alcohol at risk levels and the perceptions of medical and surgical nurses in limiting their teaching
Initiatives regarding at-risk alcohol use and their experiences of alcohol withdrawal in this demographic. Investigations are necessary to facilitate the nurses' understanding to facilitate a change of practice to address the elderly using alcohol at risk levels and initiate the appropriate nursing action to lessen the harmful effects of continued at-risk alcohol consumption.

A further implication for research is necessary to investigate the experience of administering the CAGE Questionnaire and learning more about the barriers that impact screening for at-risk alcohol use. It would be important to determine if the barriers experienced are restricted to the CAGE Questionnaire and to develop optimal methods to support nurses as they apply screening tools pertaining to such sensitive topics as alcohol use through application of therapeutic interviewing skills. The discrepancy between the finding of this study, that participants had negative views of the CAGE, and the (positive) findings in the literature suggest that there may be something particular about the study participants' work environment or circumstances. While it is not possible to generalize these and other findings of this study to nurses in general, this finding does warrant a replication of this study.

Conclusion

This research study has offered a deeper understanding of the meanings and interpretations that medical and surgical nurses attribute to alcohol abuse and alcohol dependence. The findings provide insight into issues that arise in the practice setting and into the challenges that nurses may experience when nursing patients using alcohol at risk levels. The findings have implications for nursing practice, administration, education, and research to support medical and surgical nurses to meet and maintain practice standards as they provide nursing care to this complex patient cohort.
REFERENCES


Canadian Center on Substance Abuse (CCSA) and Centre for Addiction and Mental Health (CAMA). (1999). *Canadian Profile: Alcohol, Tobacco, and other Drugs*. Ottawa, ON: Canadian Centre on Substance Abuse and Center for Addiction and Mental Health.


regarding the diagnosis and treatment of alcoholism. *Journal of the American Medical Association, 261*(21), 3115-3201.


Ottawa, ON: Author.

Office.

*Handbook of alcoholism treatment approaches: Effective alternatives.* (pp 53-65).
London: Needham.

Hesketh, K., Duncan, C., Estabrooks, M., Reimer, P. Giovannetti, K., Hyndman, K. Acorn, S.
(2003). Workplace violence in Alberta and British Columbia hospitals. *Health Policy*


Clinics of North America, 24*(1), 1-12.

in the criminal justice system.* Rockville, MD: U.S. Department of Health and Human
Services.

Practice Nurse: Alcohol Withdrawal in the Acute Care Setting.* Philadelphia, PA:
International Society of Psychiatric Mental Health Nurses.


Ministry Of Health Services (2004). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, B.C.


About the Use of Terminology in this Study

Throughout the literature, there is a perplexing array of terms concerning our understandings of alcohol use and those individuals challenged with alcohol-related problems. Such terms have evolved in both social and academic contexts. Thus, terms that have been used historically to describe health-damaging alcohol consumption include “alcohol problem”, “alcoholism”, “drunkenness”, “alcohol dependence”, or “alcohol abuse”; the person who uses alcohol to excess has been called a “problem drinker”, an “alcoholic”, an “inebriate”, or, more recently, a “high-risk alcohol user”. It is very important that the terminology used in this practice discipline be explicit, precisely defined, and used consistently to aid clinical and scientific communication as there are implications for patients (e.g. stigma), programs (e.g. treatment access), and policy (e.g. appropriation of health care funding (Kelly, 2004). The choice of language can affect the way patients perceive themselves and how they are perceived and treated by others in relation to their problems. For example, when we refer to an individual as an “alcoholic” versus “an individual with, or suffering from a dependence on alcohol” we may increase the stigma and shame associated with such problems and make accessing treatment more difficult. In this study, I have made every attempt to limit the use of obsolete and pejorative terms. However, there are some terms that a majority of scholars now considers obsolete but that still appear in the literature. I include such terms only when citing the work of a scholar who has used them, and in quotations from participant interviews or the historical literature.
Diagnostic Definitions in this Study

For the purposes of this study, and to avoid confusion, I rely on the following diagnostic definitions. The first four, alcohol dependence, alcohol abuse, alcohol withdrawal, and alcohol-withdrawal delirium are based upon the American Psychiatric Association’s criteria (DSM-IV-TR, 2000). In establishing a context and an understanding of at-risk alcohol use, the criteria are based on the Low-Risk Drinking Guidelines as developed by a Canadian team of medical and social researchers from the University of Toronto and the Center for Addiction and Mental Health (Center for Addiction and Mental Health, 2003).

Alcohol Dependence

Alcohol Dependence is a maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

1. tolerance, as defined by either of the following:
   a. a need for markedly increased amounts of alcohol to achieve intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of alcohol
2. withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for alcohol
   b. alcohol is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control alcohol use
5. a great deal of time is spent in activities necessary to obtain alcohol, using alcohol, or recovering from its effects
6. important social, occupational, or recreational activities are given up or reduced because of alcohol use
7. alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by its use (e.g. an ulcer was made worse by alcohol consumption)
**Alcohol Abuse**

Alcohol Abuse is a maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring with a 12 month period:

1. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to alcohol use; alcohol-related)
2. Absences, suspensions, or expulsions from school; neglect of children or household
3. Recurrent alcohol use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by alcohol use)
4. Recurrent alcohol-related legal problems (e.g. arrests for alcohol related disorderly conduct)
5. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g. arguments with spouse about consequences of intoxication, physical fights)

**Alcohol Withdrawal**

1. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
2. Two (or more) of the following, developing within several hours to a few days after Criterion A.
   - Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
   - Increased hand tremor
   - Insomnia
   - Nausea or vomiting
   - Transient visual, tactile, or auditory hallucinations or illusions
   - Psychomotor agitation
   - Anxiety
   - Grand mal seizures
3. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. The symptoms are not due to a general medical condition and are not better accounted for by another medical disorder.
Alcohol-Withdrawal Delirium – Delirium Tremens

(1) Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.

(2) A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.

(3) The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

(4) There is evidence from the history, physical examination, or laboratory findings that the symptoms are in excess of those usually associated with the withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the cognitive symptoms are in excess of those usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Guidelines For Low-risk and High-risk (or At-risk) Alcohol Use

Low-risk Drinking Guidelines

Zero drinks = lowest risk of an alcohol-related problem

Women: up to 7 standard drinks per week (i.e. one drink per day) and no more than 3 drinks on any given occasion

Men: up to 14 standard drinks per week (i.e. two drinks per day) and no more that 4 drinks on any given occasion

Seniors: male and female over 65 years of age – no more than 7 drinks per week (i.e. 1 per day) and no more than 3 on any given occasion

High-Risk or At-Risk Alcohol Use

Alcohol use outside the above guidelines based on the following quantities:

One “Standard Drink” = 13.6 g of alcohol
5 oz/142 ml of wine (12% alcohol)
1.5 oz/43 ml of spirits (40% alcohol)
12 oz/341 of regular strength beer (5% alcohol)
Terminology no Longer in Use

It is important to note that although in the nursing literature, once commonly seen terms such as “alcoholic”, “alcoholism” and “problem drinker” have been replaced by “alcohol abuse” and “alcohol dependence”, in the practice setting these obsolete terms continue to be used.
APPENDIX B

The CAGE and CAGE-AID Questions
(CAGE Adapted to Include Drugs)

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

   Yes       No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

   Yes       No

3. In the last three months, have you felt guilty or bad about how much you drink or use?

   Yes       No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

   Yes       No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicates a probable problem.

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs are the original CAGE questions modified by the italicized text.

APPENDIX F

Demographic Questionnaire

Code Number: _____

Please answer the following questions by marking the correct choice where appropriate and filling in the blanks.

1. Age
   _______ 20 – 29
   _______ 30 – 39
   _______ 40 – 49
   _______ 50 – 59
   _______ 60 – retirement

2. Gender: _____Female _____Male

3. Educational Preparation in Nursing:
   _______ Diploma _______ Year awarded
   _______ Baccalaureate Degree _______ Year awarded
   _______ Masters Degree _______ Year awarded

4. Time worked in nursing _____(years) _____(months).

5. Time worked in a medical/surgical area _____

6. Please circle the unit you work(ed) in:
   medical surgical
convenience. You are aware that your participation in this study is voluntary and will in no way affect your employment. You know that you are free to withdraw from the study at any time, stop the tape recording at any time, refuse to answer questions, ask for any taped message to be erased, and ask for any sensitive information not to be divulged.

Disadvantages and risks for your participation include the investment of your time and the possibility you might experience some discomfort or anxiety associated with the subject matter being discussed. Although it is unlikely, if for any reason you become upset by the questions or the feelings the questions might arouse, at your request, the researcher will stop the interview. You will be provided with the names of support services. You will not be financially compensated and you will receive no direct benefit from your participation in this study. However, you may receive some satisfaction from contributing to this limited body of knowledge. You might also experience some satisfaction from telling your story from a Canadian perspective and feeling that you have been heard.

You understand that confidentiality will be maintained by assigning each participant a code number. Biographical details will be altered as necessary in published and unpublished work to mask identifying characteristics of the participants and institutions.

You have been assured that the names of participants will not appear in any materials, tapes, and transcriptions will not be made available to any employers or administrators. The data will be kept secured in a locked filing cabinet and be available to the researcher and the members of the researcher's committee for the purpose of analysis and writing of the research report. The researcher will utilize the data for future publications, presentations, and possible secondary analysis at a later date. The tapes will be destroyed within five years of completing the study.

You understand that Heather, if asked, will offer follow-up interviews and/or educational sessions to all participants to make the study results available once it is completed.
You will have access to your own interview transcripts as well as the complete thesis. If you have any questions or desire further information with respect to this study, you may call Dr. Carol Jillings. If during the study, you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Your signature indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

_______________________________________
Subject Signature                        Date

_______________________________________
Signature of a Witness                  Date

Receipt of: “Invitation Letter to Participate” acknowledged
APPENDIX H

Grand Tour Questions:

I am interested in what your meanings and interpretations of alcohol abuse and alcohol dependence as you screen and assess for at risk alcohol use.

1. What influences your thinking about alcohol abuse and alcohol dependence?
2. How do your feelings and experiences affect your thinking about the patient using alcohol at risk levels?

Mini Tour Questions:

1. Tell me about a patient you have cared for who used alcohol at risk levels?
2. Does screening and assessment for at risk alcohol use differ from screening and assessment for other conditions?
3. Do you have any experience(s) of alcohol abuse and alcohol dependence that stands out in your mind or affected your thinking in a different way?
4. Do you have any experiences in caring for an alcohol dependent patient that you consider as having particular significance?
5. Tell me of an experience where assessment and screening of at risk alcohol use went well.
6. Tell me of an experience where assessment and screening of at risk alcohol use did not go well.
7. What is your experience(s) of caring for an alcohol dependent patient?
8. Tell me about an experience when caring for an alcohol dependent client that went well.
9. Tell me about an experience of caring for an alcohol dependent client that did not go well.
10. Do you believe screening and assessment for at risk alcohol use could be better?
11. What would need to happen for screening and assessment to be better?
12. Are you able to tell me of an experience regarding alcohol abuse or alcohol dependence that as a person (not as a nurse) you believe affected you in some way?